

Federally-Facilitated Exchanges (FFE)s and Federally-Facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual

This manual is effective as of September 2, 2020. All enrollments made on or after September 2, 2020, should be processed in accordance with the operational requirements set forth in this document.

CMS intends to update this manual regularly and publish clarifying bulletins between updates. All previous versions of bulletins that have been incorporated into this version of the manual should be considered superseded by this manual. If you have questions related to content posted within this manual, please email CMS_FEPS@cms.hhs.gov.

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1. INTRODUCTION AND SCOPE

1.1 Background

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this manual, the two laws are referred to collectively as the Patient Protection and Affordable Care Act (PPACA). The PPACA creates new competitive private Health Insurance Exchanges that enable qualified individuals (QIs) to shop for, select, and enroll in quality, affordable private health plans. The Exchanges also allow QIs to obtain eligibility determinations or eligibility assessments for coverage under Medicaid, the Children’s Health Insurance Program (CHIP), and the Basic Health Program (BHP), where applicable. In addition, the PPACA created Small Business Health Options Program (SHOP) Exchanges that enable qualified employers to provide health plans to their employees. QIs and qualified employers have been able to obtain coverage from private health insurance companies through the Exchanges since October 1, 2013, for coverage beginning January 1, 2014.¹

1.2 Types of Exchanges

The Exchanges established by the PPACA are established in one of several different ways, including as a:

- **State-Based Exchange (SBE):** A state that elected to establish its own Exchange operates an SBE.
- **Federally-Facilitated Exchange (FFE):** Pursuant to Section 1321(c)(1) of the PPACA, the federal government established FFEs in any state that did not elect to establish an SBE, or in a state that the Secretary of the Department of Health & Human Services (the Secretary) determined would not have an operable Exchange.
- **State-Based Exchange – Federal Platform (SBE-FP):** An SBE-FP uses the federal eligibility and enrollment platform operated by the FFEs for its eligibility and enrollment functions, but is directly responsible for completing other functions, including, but not limited to, plan management. An SBE-FP, like all other Exchange types, is required to provide entry points for Medicaid/CHIP enrollees (by phone, website, and paper application), as well as Medicaid consumer support (by phone, website, and the Marketplace Call Center).
- **State-Based Small Business Health Options Program (SB-SHOP):** An SB-SHOP is a type of SBE designed to assist qualified employers in facilitating the enrollment of their employees in qualified health plans (QHPs) offered in the small group market.
- **Federally-Facilitated Small Business Health Options Program (FF-SHOP):** An FF-SHOP is a type of FFE designed to assist qualified employers in facilitating the enrollment of their employees in QHPs offered in the small group market.

1.3 Purpose of Document

This manual provides operational policy and guidance on key topics related to eligibility and

¹ For background information, see section 1311(b)(1) of the PPACA and 45 CFR §155.410(c)(i).

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enrollment within the FFEs and FF-SHOPs, as well as within the SBE-FPs, which use the federal platform for eligibility and enrollment. For ease of reference, this document will use the terms “FFEs” and “FF-SHOP” to refer to all individual market Exchanges and SHOPs that rely on the federal eligibility and enrollment platforms.

Where necessary, CMS will indicate whether the guidance described pertains to the FFEs and FF-SHOP, only the FFEs, or only the FF-SHOP. Additionally, we have indicated, where applicable, the guidance pertains to both QHPs and Exchange-certified stand-alone dental plans, which this manual refers to as qualified dental plans (QDPs).

The information provided in this document applies to organizations and entities that may be involved in or assist with enrolling a QI into a QHP and/or QDP using the FFEs eligibility and enrollment functions. These entities include:

- SBE-FPs;
- QHP and QDP issuers;
- Agents or brokers (A/B), including web-brokers, who are registered with the FFEs;
- Navigators, certified application counselors (CACs), and caseworkers;
- Third-party administrators (TPAs) of QHPs, QDPs, or employer-sponsored coverage; and
- Trading partners of QHP and QDP issuers, such as healthcare clearinghouses.

1.4 Acronyms and Definitions

1.4.1 Acronyms

Exhibit 1 and the subsection that follows describe the commonly used acronyms and terms that appear throughout this document.

Exhibit 1: Commonly Used Acronyms

Acronyms	Descriptions
AMRC	Additional Maintenance Reason Code
API	Application Programming Interface
APTC	Advance Payments of the Premium Tax Credit
A/B	Agent or Broker
BAR	Batch Auto-Reenrollment
BHP	Basic Health Program
BUU	Batch Update Utility
CAC	Certified Application Counselor
CCIO	Center for Consumer Information and Insurance Oversight
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CIC	Change in Circumstance
CSR	Cost-sharing Reduction

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Acronyms	Descriptions
DE	Direct Enrollment
DMI	Data Matching Issue/Inconsistency
DSH	Data Services Hub
EDI	Electronic Data Interchange
EDE	Enhanced Direct Enrollment
EDS	External Data Source
EDN	Eligibility Determination Notice
EFT	Electronic Fund/File Transfer
EHB	Essential Health Benefits
EIN	Employer Identification Number
ER&R	Enrollment Resolution and Reconciliation
FFE s	Federally-Facilitated Exchanges
FF-SHOP	Federally-Facilitated Small Business Health Options Program
FPL	Federal Poverty Level
HHS	Department of Health & Human Services
HICS	Health Insurance Casework System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIOS	Health Insurance Oversight System
HRA	Health Reimbursement Arrangement
ICHRA	Individual Coverage Health Reimbursement Arrangement
IRS	Internal Revenue Service
LC	Life Change
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
MCR	Marketplace Consumer Record
MLR	Medical Loss Ratio
MOEN	Marketplace Open Enrollment Notice
OEP	Open Enrollment Period
PBP	Plan Benefit Package
PCL	Plan Category Limitations
PMP/PP	Partial Month Premium/Premium Proration
PPACA	Patient Protection and Affordable Care Act
PTC	Premium Tax Credit

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Acronyms	Descriptions
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
QI	Qualified Individual
QSEHRA	Qualified Small Employer Health Reimbursement Arrangement
RA	Risk Adjustment
RCNI	Reconciliation Inbound
SBE	State-Based Exchange
SBE-FP	State-Based Exchange – Federal Platform
SEP	Special Enrollment Period
SOAP	Simple Object Access Protocol
TPA	Third-Party Administrator
UEFF	Unauthorized Enrollment Finder File

1.4.2 Definitions

Form 1095-A: A tax form (like a W-2) that the Exchange furnishes to individuals who are enrolled in Qualified Health Plans (QHPs) through the Exchange. The Form 1095-A provides enrollees with information about their health coverage so they can file their taxes, reconcile APTC, and claim the PTC.

Advance Payments of the Premium Tax Credit (APTC): APTC, also known as advance payments of the premium tax credit, can be used by eligible taxpayers who are enrolled in QHPs through an individual market Exchange to lower their monthly premium costs. Eligible taxpayers may choose how much APTC to apply to their premiums each month, up to a maximum amount, which is then paid directly to the insurer. The APTC must be reconciled with the PTC on an individual's federal income tax return. If the APTC amount received for the year is less than the PTC, the individual will receive the difference as a higher refund or lower tax due. If the APTC amount received for the year is more than the PTC, the excess advance payments may have to be repaid with the individual's tax return.

Agent or Broker (A/B): A/B has the meaning set forth in 45 CFR §155.20.

Applicant: Applicant has the meaning set forth in 45 CFR §155.20.

Application Filer: Application filer has the meaning set forth in 45 CFR §155.20.

Auto-Reenrollment (Passive): Auto-reenrollment is an enrollment transaction that continues coverage in the individual market FFEs for the new plan year for an enrollee who does not actively select a plan for the new plan year during the OEP automatically without a lapse in coverage, if timely premium payment is made.

Batch Auto-Reenrollment (BAR): BAR is the process the individual market FFEs use to implement

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auto-reenrollment.

Consolidated Omnibus Budget Reconciliation Act (COBRA): COBRA is federal legislation that amended the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and the Public Health Service Act to provide for continuation of group health coverage that otherwise might be terminated. COBRA contains provisions giving certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of group health plan coverage at group rates. This coverage, however, is available only when coverage under the group health plan is lost due to specific events.

Cost-sharing Reduction (CSR): CSR has the meaning set forth in 45 CFR §155.20.

Data Matching Issue/Inconsistency (DMI): When an application filer provides information to the Marketplace as a part of the application process and the information the application filer provided does not match the information received by the Exchange from its trusted data sources, such as the Office of Personnel Management, Department of Homeland Security, or Social Security Administration, a DMI results. The application filer needs to resolve DMIs related to citizenship or immigration within 95 days, and all other DMIs within 90 days. Otherwise, the enrollee's enrollment through the Marketplace may be terminated and/or the enrollee's APTC and CSR may be terminated or adjusted, if applicable.

Electronic Data Interchange (EDI): EDI is an automated transfer of data in a specific format following specific data content rules between a Marketplace and a QHP or QDP issuer. EDI transactions are transferred electronically through HealthCare.gov or an SBE.

Enrollee: Enrollee has the meaning set forth in 45 CFR §155.20.

Enrollment Group (in the individual market FFEs): All QIs enrolled and linked by the Marketplace-assigned policy identifier. Additional QIs may be linked by the policy Marketplace identifier, such as a custodial parent, but may not be considered part of the enrollment group.

Enrollment Data Alignment: The ongoing processes used to ensure consistency of enrollment and financial data between issuers and the FFEs. Since CMS makes payment of APTC to QHP issuers based on the enrollment files, all entities' enrollment data must be reconciled. In addition, the enrollment data stored in the FFEs are used as the basis for annual generation of Form 1095-A tax data for QIs. Discrepancies can arise when an issuer accepts a change from an enrollee based on HICS instructions (i.e., a change that has not been reflected in the FFEs, but one that the reconciliation process identifies) and enters it directly into its system. By regulation, issuers are required to reconcile enrollment information with the FFEs at least monthly.

Full-time Employee: For SHOP eligibility purposes, an employee who is employed, on average, at least 30 hours of service per week (26 U.S.C. §4980H, 26 CFR §54.4980H-1(a)(21), and 45 CFR §155.20). For purposes of the Small Business Health Care Tax Credit, a full-time employee is an employee who is employed, on average, at least 40 hours of service per week (26 U.S.C. §45R).

Health Insurance Casework System (HICS): The authorized and secure electronic system recognized and used by the FFEs to input, track, and monitor QIs' and enrollees' concerns, unresolved issues, complaints, and cases that are not able to be resolved by CMS. The FFEs use HICS to

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appropriately assign unresolved cases and communicate effective date changes to issuers for resolution, when appropriate.

Health Reimbursement Arrangement (HRA): An HRA is an account-based group health plan funded solely by employer contributions that reimburses an employee's medical care expenses up to a maximum dollar amount for a coverage period (for example, a calendar or non-calendar year). Medical care expenses means expenses for medical care as defined under section 213(d) of the Internal Revenue Code. An employer may allow unused amounts to be rolled over to be used in subsequent years. In addition to the employee, an HRA may also reimburse expenses incurred by the employee's spouse, dependents, and children who, as of the end of the taxable year, have not attained age 27 (dependents). HRAs are sometimes called Health Reimbursement Accounts.

Insurance Affordability Programs: APTC and CSR, as well as Medicaid, CHIP, and, where applicable, BHP coverage.

Individual Coverage Health Reimbursement Arrangement (ICHRA): A type of HRA that requires eligible employees and dependents to have individual health insurance coverage or Medicare Parts A (Hospital Insurance) and B (Medical Insurance) or Part C (Medicare Advantage). Reimbursements by the ICHRA may include premiums and cost sharing for individual health insurance coverage, and for Medicare; employers could begin offering ICHRAs as of January 1, 2020.

Life Change (LC): A circumstance that could affect an applicant's or enrollee's eligibility for enrollment through the Marketplace or for insurance affordability programs (e.g., birth, adoption, foster care, change in household income). LCs that are not reported to the applicable Marketplace could potentially lead to an enrollee or applicable tax filer repaying all or some of the APTC the enrollee received during the year.

Marketplace Account: The Marketplace account provides an individual with a username and password to create an individual application and perform other functions related to obtaining health coverage through a Marketplace. A Marketplace account user does not need to be the policyholder for coverage purchased from applications submitted by the Marketplace account user.

Minimum Essential Coverage (MEC): MEC is the type of coverage an individual must have to meet the individual shared responsibility requirement under the PPACA. The MEC requirement can be fulfilled by a number of different types of coverage outlined in section 5000A(f) of the Internal Revenue Code and in 45 CFR §156.602, such as individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other types of coverage.

Modified Adjusted Gross Income (MAGI): MAGI is the figure used to determine eligibility for insurance affordability programs in the Marketplaces, and for Medicaid and CHIP. Generally, MAGI is an individual's adjusted gross income plus certain other income, including tax-exempt Social Security, interest, or foreign income, and without certain deductions allowed for adjusted gross income (26 CFR §1.36B-1(e)(2) and 42 CFR §435.603).

Open Enrollment Period (OEP): The period each year during which a QI may enroll or change coverage in an individual market QHP through the Marketplace (45 CFR §155.20).

Partial Month Premium/Premium Proration (PMP/PP): Occurs in the Exchange when an enrollee

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has periods of coverage that last less than a full month. In the FFEs and FF-SHOP, the pro-rated monthly premium for partial coverage months is calculated based on the actual number of days that the applicable enrollee or enrollees has/have coverage. Specifically, the premium is prorated as follows: the full month premium for one month of the coverage is divided by the number of days in the month. The result of the calculation is multiplied by the number of days in which the enrollee had coverage during the partial coverage month.

Plan Year: Plan year has the meaning set forth in 45 CFR §155.20.

Plan Category Limitations (PCL): Established in the 2017 Market Stabilization Rule, enrollees and their dependents, including newly added household members, who qualify for common SEPs, like a loss of health insurance, moving, or a change in household size, are generally only able to enroll in a plan from their current plan category. See 45 CFR §155.420(a)(4).

Product: Product has the meaning set forth in 45 CFR §144.103.

Qualified Health Plan (QHP): A health insurance plan that meets certain requirements and, on the basis of meeting those requirements, is certified to be sold through an Exchange. A QHP must be certified by each Exchange through which it is sold. QHP has the meaning set forth in 45 CFR §155.20.

QHP Issuer: QHP issuer has the meaning set forth in 45 CFR §155.20.

Qualified Individual (QI): QI has the meaning set forth in 45 CFR §155.20.

Qualified Employee: Qualified employee has the meaning set forth in 45 CFR §155.20.

Qualified Employer: Qualified employer has the meaning set forth in 45 CFR §155.20.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA): A type of HRA created in the 21st Century Cures Act, which permits small employers who don't offer group health plan coverage to any of their employees to provide a QSEHRA to their eligible employees. An eligible employee can use a QSEHRA to reimburse medical care expenses, as that term is defined under section 213(d) of the Internal Revenue Code, for him or herself, as well as any covered dependents (if permitted by the employer). To receive reimbursements from a QSEHRA, an employee and any covered dependents must be enrolled in MEC. Small employers could provide QSEHRAs for plan years beginning on or after January 1, 2017.

Reinstatement: Reinstatement is the correction of an erroneous termination or cancellation action that results in the restoration of an enrollment with no break in coverage (45 CFR §155.430(e)(3)).

Reenrollment (Active): An 834 enrollment transaction that continues enrollment in coverage through the individual market Exchange for an enrollee who actively returns to the Exchange, generally during the OEP, to make a plan selection for the new plan year.

SHOP Application Filer: SHOP application filer has the meaning set forth at 45 CFR §155.700(b).

Small Employer: Small employer has the meaning set forth in 45 CFR §155.20.

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Special Enrollment Period (SEP): SEP has the meaning set forth in 45 CFR §155.20.

Subscriber: A subscriber is the individual enrolling in coverage who has elected benefits for an enrollment group or the person for whom benefits have been elected by the application filer in the event that the application filer is not the person enrolling in coverage. There is always only one subscriber per enrollment group and each member of the enrollment group will be associated with the subscriber. The subscriber may also be referred to as the anchor for the group.

Tax Filer: A tax filer is an individual who will file taxes for the coverage year on behalf of a tax household.

Web-broker: A web-broker is an individual A/B, group of A/Bs, or business entity registered with the FFE under §155.220(d)(1) that develops and hosts a non-Exchange website that interfaces with an Exchange to assist consumers with DE in QHPs offered through the Marketplace as described in 45 CFR § § 155.220(c)(3) and 155.221.

1.4.3 Additional Resources

Exhibit 2 lists contact information for additional resources referenced throughout this manual.

Exhibit 2: Additional Resources

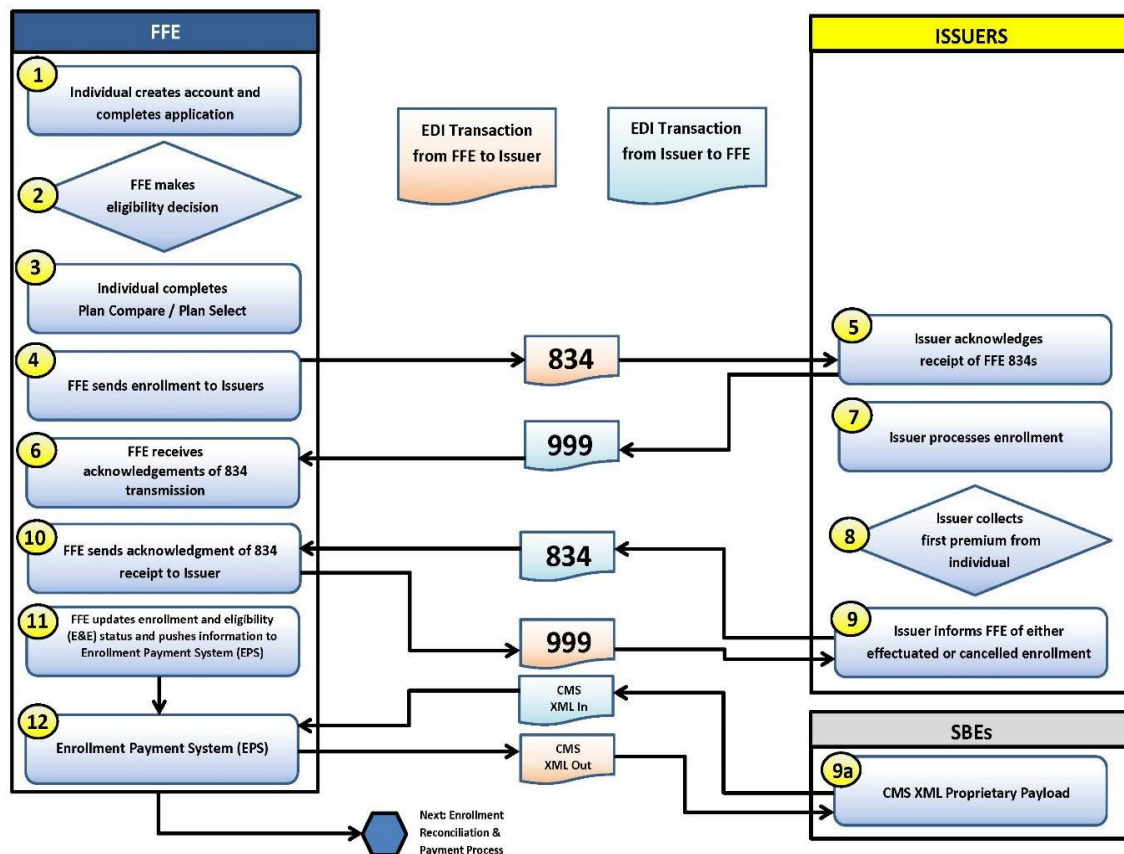
Resources	Contact Information
CCIIO	www.cms.gov/ccio
Marketplace Call Center	1-800-318-2596 1-855-889-4325 (TTY)
HealthCare.gov	www.healthcare.gov
Medicaid	www.medicaid.gov
Medicare	www.medicare.gov
Registration for Technical Assistance Portal (REGTAP)	www.regtap.info
FF-SHOP Hotline	1-800-706-7893 1-888-201-6445 (TTY)
CMS zONE	https://zone.cms.gov
Marketplace Service Desk (MSD)	CMS_FEPS@cms.hhs.gov 1-855-CMS-1515
HICS	hics@cms.hhs.gov 1-888-205-0684
Agent/Broker Help Desk	FFMProducer-AssisterHelpDesk@cms.hhs.gov

For instructions on registering for CMS zONE, visit https://www.regtap.info/reg_librarye.php?i=2466.

2. ENROLLMENT IN THE INDIVIDUAL FFEs (APPLICABLE TO QHPs/QDPs)

For qualified individuals (QIs) to purchase coverage in a Qualified Health Plan/Qualified Dental Plan (QHP/QDP) through the Federally-Facilitated Exchanges (FFEs), QIs must enroll in coverage through the FFEs during an Open Enrollment Period (OEP) or qualify for a special enrollment period (SEP) (see Section 6). **Exhibit 3** depicts a high-level, end-to-end system flow of the process for a QI to enroll in a QHP/QDP through the FFEs. Please refer to Exhibit 3 when reviewing the enrollment instructions in the succeeding sections. Exhibit 3 does not pertain to Direct Enrollment (DE). Please refer to Section 5 for the DE process.

Exhibit 3: FFE Enrollment Process



2.1 Eligibility

Pursuant to 45 CFR §155.405, an individual completes a single streamlined application for enrollment in coverage through the Exchange. The Exchange uses this single streamlined application to determine both the QI's eligibility to purchase coverage through the Exchange and, if the applicant chooses to apply for insurance affordability programs, the QI's eligibility for advance payments of the premium tax credit (APTC), Cost-Sharing Reduction (CSR), and in some states, Medicaid and Children's

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Health Insurance Program (CHIP).²

2.1.1 Requirement to File and Reconcile Past APTC

CMS regulations require that Exchanges determine that QIs are not eligible for APTC if they had APTC paid on their behalf for a prior year but their tax filer did not file a federal income tax return and reconcile APTC for that year (45 CFR §155.305(f)(4)). When a tax filer does not comply with this requirement, it is known as “Failure to File and Reconcile” or “FTR.” The FTR requirement first took effect in the 2016 coverage year; 2014 was the first year of Exchange coverage and therefore the first year tax filers were required to reconcile APTC on their annual federal income tax returns was in 2015 for the 2014 tax year.

2.1.2 Medicaid & CHIP Eligibility

Depending on a state’s election, the FFEs either make final eligibility determinations for Medicaid and CHIP based on the applicant’s Modified Adjusted Gross Income (MAGI) or assess the applicant’s potential eligibility for Medicaid and CHIP based on their MAGI. In an assessment state, the state Medicaid/CHIP agencies make the final eligibility determinations for QIs assessed as potentially eligible by the FFEs.

In all states, the FFEs screen applicants for potential eligibility for Medicaid based on criteria other than MAGI, and transfer applications screened as potentially eligible on a basis other than MAGI to the state Medicaid agency for full eligibility determinations. Applicants who believe they may be eligible for Medicaid on a basis other than MAGI may also request that their applications be transferred to the state Medicaid agency for a full eligibility determination. Medicaid and CHIP applicants always have the option to apply for Medicaid and CHIP through their state Medicaid/CHIP agency directly.

2.2 Open Enrollment and Coverage Effective Dates

During the OEP, a QI may enroll in a QHP. The QI can make multiple elections during the OEP, and may change plans, even if the original selection’s coverage (active or passive) has been effectuated. However, the last election made by the end of the OEP that is effectuated will be the coverage in which the QI is enrolled through the FFEs. If the QI enrolled in a QHP and paid for the first month’s premium payment (i.e., binder payment), as required by 45 CFR §155.400(e), but then selected another QHP during the OEP and that enrollment is effectuated for the same coverage effective date, the initial issuer of the QHP in which coverage was previously effectuated will need to cancel the coverage and refund premiums. The initial issuer of that QHP will receive notification of the plan selection change from the Marketplace. Outstanding enrollments will also be identified during enrollment reconciliation.

The coverage effective date for plan selections made during the OEP generally is January 1 of the following calendar year. However, QIs who qualify for an SEP during the OEP may receive a coverage effective date as indicated in Section 6. Effective dates for enrollee changes to plan selection post-effectuation align with normal effective dates as established in 45 CFR §155.410(f) (although for some SEPs, accelerated or retroactive effective dates may apply). An enrollee can change plans by contacting the Marketplace Call Center or by logging into their HealthCare.gov account, accessing

² Currently, no FFE or SBE-FP states make eligibility determinations for a BHP.

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“My Plans and Programs,” and selecting “Change Plan.” Enrollees may change plans during a valid enrollment period without reporting life changes on their applications.

Note that, under 45 CFR §155.310(c), the FFEs must accept an application and make an eligibility determination at any point in time during the year. Eligibility determinations made outside the OEP can enable individuals to learn whether they are QIs, whether they are eligible for an SEP for FFE coverage, whether they are eligible for APTC/CSR, or whether they are eligible for Medicaid or Children’s Health Insurance Program (CHIP). There are generally no restrictions on when a QI can enroll for Medicaid or CHIP.

Exhibit 4 illustrates OEP plan selection and coverage effective dates for upcoming plan years.

Exhibit 4: Coverage Effective Dates for the FFE OEP

Plan Selection Date	Coverage Effective Date
November 1 – December 15	January 1 of the following calendar year

2.3 Enrollment Transactions

Federal regulation (45 CFR §155.270) requires each Exchange to use standards, implementation specifications, operating rules, and code sets adopted by HHS under Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act (PPACA) when conducting certain electronic transactions with a covered entity, such as a QHP issuer.

Additionally, HHS oversees and monitors FFE issuers and non-Exchange entities to verify compliance with security and privacy standards, as required by 45 CFR §155.280.

The Exchange, QHP, and QDP issuers transmit enrollment transactions in files using the Accredited Standards Committee (ASC) X12 834 Benefit Enrollment and Maintenance Version 5010 (834 enrollment transaction), adopted by the Secretary on January 23, 2009.

CMS released an ASC X12 834 Standard Companion Guide to be used in conjunction with the ASC X12 Version 005010 834 TR3, which outlines transactional information. Additionally, a Maintenance 834 Operations Manual was published by CMS to explain how certain new data elements, such as APTC and CSR data in the FFEs, and employer and qualified employee premium contributions in the Federally-Facilitated Small Business Health Options Program (FF-SHOP), will be included in the existing version of the 834 enrollment transaction. Issuers offering QHPs or QDPs through the FFEs must use the ASC X12 834 enrollment transaction in combination with the updated Companion Guide and Operations Manual for purposes of enrollment transactions. Both documents can be found on CMS zONE at their respective links below:

Federally-Facilitated Marketplace Maintenance 834 Operations Manual:

<https://zone.cms.gov/document/federally-facilitated-marketplace-maintenance-834-operations-manual>

ASC X12 005010 834 Companion Guide:

<https://zone.cms.gov/document/asc-x12-005010-834-companion-guide>

For purposes of transmitting enrollment information to QHP and QDP issuers, the FFEs transmit daily electronic files to the issuers, or their trading partners, in the adopted 834 enrollment transaction. Errors will be reported using the ASC X12 acknowledgement transactions, including the TA1 and the 999, for syntax and content. This information is explained in greater detail in the Companion Guide.

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Retroactive transactions can have either an enrollment or a termination outcome, which could result in impacts to payments including adjustments to APTC and CSR, as well as other enrollee information, since they are based on plan benefit start and end dates. Retroactive effective dates can result from unforeseen life events, such as death; from FFE or issuer error, such as incorrect data being manually entered from a paper application; or from an administrative process, such as an eligibility appeal decision. Many of the events and circumstances that result in retroactivity are addressed by regulations on terminations (45 CFR §155.430(d)), SEPs (45 CFR §155.420(b)), redeterminations (45 CFR §155.330(f)), and appeals of eligibility determinations for Exchange participation and insurance affordability programs (45 CFR §155.545(c)). For more information on these topics please refer to Section 3, Redeterminations and Renewals in the FFEs, and Section 8, Terminations.

The retroactive enrollment or termination effective dates for these triggering events and circumstances are outlined in the respective sections of the regulations. Examples of unique circumstances that may involve retroactive enrollment include those where, if a QI fulfilled all enrollment requirements, but, for some reason, the FFEs or QHP/QDP issuer was unable to process the enrollment for the required effective date, the FFEs may process a retroactive enrollment effective date. If an enrollment was never processed, or if a valid termination request was properly made, but not processed or acted on by the FFEs or the QHP/QDP, the FFEs may grant retroactive terminations. Those circumstances will be addressed on an individual basis, and determinations of outcomes will be decided by the FFEs in collaboration with issuers, when needed.

In most cases, issuers will receive an 834 transaction from the Exchange, which communicates the correct retroactive enrollment or termination effective dates. However, in some cases (e.g., an eligible enrollee opts for retroactive effect of an appeal decision), CMS notifies the issuer(s) using the Health Insurance Casework System (HICS), which specifies the effective date for the retroactive enrollment or termination and/or application of APTC/CSR amounts.

Unlike a reinstatement, which is a correction of records with the practical effect of “erasing” a prior disenrollment, a retroactive enrollment is an action to enroll a QI into a QHP or QDP for a new time period. Reasons and effective dates for retroactive enrollments and terminations are outlined in **Exhibit 5** and **Exhibit 6**. In some limited cases, CMS may determine that a QI is eligible for an SEP due to an extraordinary circumstance beyond the QI’s control and may also permit retroactive enrollment and termination as necessary.

Exhibit 5: Retroactive Enrollment Reasons and Dates

Reason	Effective Date
Birth, Adoption, Placement for Adoption, or Placement in Foster Care	Date of Event
FFEs or QHP/QDP Issuer Error	Date to Be Determined (TBD) by the FFEs
Exceptional Circumstances	Date to Be Determined (TBD) by the FFEs
Eligibility Appeals Outcome	Date TBD by Appeal Outcome

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Exhibit 6: Retroactive Termination Reasons and Dates³

Reason	Effective Date
Death	Date of Event
Rescission	Policy Start Date
Exhausted Three-Consecutive-Month Grace Period	Last Day of First Month of Grace Period
Exceptional Circumstances	Date to Be Determined (TBD) by the FFEs
FFE's Termination Error or FFEs Systems Limitations	Date to Be Determined (TBD) by the FFEs
Eligibility Appeals Outcome	Date to Be Determined (TBD) by Appeal Outcome

Exhibit 7 provides examples related to retroactivity.

Exhibit 7: Retroactivity Examples

Family Composition	Action	Outcome
Subscriber, Spouse, and Two Dependent Children	Twin dependent children born on August 1. Newborn dependents are enrolled retroactively into the family's current QHP.	The FFEs send enrollment information for the enrollment group to the issuer. The issuer receives the transactions and confirms receipt of the transactions by sending an acknowledgement to the FFEs. The issuer makes updates to its system. Coverage is effective August 1.
Subscriber and Spouse	Subscriber contacts FFE to inform FFE of spouse's sudden death three weeks prior.	The FFEs terminate the deceased enrollee's coverage with a prospective termination date. The FFEs then assigns a Category Two HICS case to the issuer specifying a retroactive termination date to be the date of death. The issuer may require additional steps to process the premium refund in accordance with applicable state law, and the FFEs recoup any APTC and adjusts issuer user fees.
Subscriber Only	Issuer sends termination transaction to FFE on October 31 for non-payment of premium for a subscriber who is receiving APTC.	The FFEs send termination information for the subscriber to the issuer. The issuer receives the transaction and confirms receipt of the transaction by sending an acknowledgement to the FFEs. The issuer makes updates to its system. The FFEs then send a notice to the subscriber regarding the termination of coverage. The retroactive termination date is August 31, the last day of the first month of the three-month grace period.

2.3.1 Initial Enrollment Transaction

Once a QI selects a QHP, and QDP if desired, the FFEs send an 834 enrollment transaction to the

³ This is not an exhaustive list.

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issuer. The FFEs accumulate transactions and send them once daily (seven days a week, except during scheduled maintenance windows).

If a QI makes a plan selection and subsequently makes a change later in the same day before daily transactions are submitted, the plan selection and the change each generate separate 834 transactions, and issuers must process each transaction in sequence based on the timestamp and Electronic Data Interchange (EDI) file. However, in order to obtain the highest level of accuracy in determining order of transactions, issuers should pay specific attention to the date time stamp on the actual 834, and not just the date and time on the EDI file.

2.3.2 Confirmation of the 834 Transaction in Individual Market FFEs

In the FFEs, once an issuer receives either full payment or payment within its established premium payment threshold in accordance with Section 7.2, Premium Payment Threshold, for any applicable initial premium due from the enrollee, and the issuer has received the initial 834 enrollment transaction, the issuer will send the FFEs a full 834 effectuation/confirmation transaction (Additional Maintenance Reason Code [AMRC] of CONFIRM). The confirmation transaction provides the FFEs verification that the issuer has effectuated enrollment.

Issuers should not wait to confirm enrollment of a QI until after the APTC is paid. For purposes of generating the confirmation transaction, full payment occurs when the issuer receives full payment (or payment within the premium payment threshold if the issuer utilizes such) of the portion of the premium for which the QI is responsible.

When a QI pays their portion of the binder payment before the coverage effective date, CMS expects QHP and QDP issuers to send the confirmation transaction to the FFEs no later than the fifth calendar day of the effective month of coverage. In the case where the binder payment is made after the effective date of coverage, but coverage is effectuated retroactively by the issuer from the date the premium payment is made, CMS expects QHP and QDP issuers to send the confirmation transaction to the FFEs without undue delay (up to 48 hours from activation of policy in issuer's system).

2.3.2.1 Examples

Example 2A: A QI selects a QHP on November 20 and is therefore assigned a coverage effective date of January 1. The monthly premium is \$200, and the issuer does not make use of a premium payment threshold. The QI is eligible for a maximum APTC of \$75 per month. The QI selects the maximum APTC and, therefore, is responsible for a monthly premium payment of \$125. The issuer has established a premium payment deadline of the coverage effective date. The QI is, therefore, required to make payment of initial month's premium of \$125 to the QHP issuer no later than January 1. The QHP issuer receives payment of \$125 from the QI on December 31. The QHP issuer then sends the FFEs the 834 confirmation transaction on January 2. The QHP issuer has met the FFE's expectation for timely transmission of the confirmation transaction.

Example 2B: Same circumstances as Example 2A, except the QI mails a payment of \$100 on December 16. The issuer receives the payment on December 18. The enrollee makes an additional payment towards the initial month's premium of \$25 on December 21, and the issuer receives the payment on December 28. The QHP issuer then sends the FFEs the 834 confirmation transaction on December 30. The QHP issuer has met the FFE's expectation for timely transmission of the confirmation transaction.

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Additional information on 834 effectuation transactions to the individual FFEs can be found at the ASC X12 005010 834 Companion Guide linked earlier in this chapter.

2.3.3 Cancellations in the Individual Market FFEs

Pursuant to 45 CFR §155.430(e)(2), a cancellation transaction is a specific type of termination that ends a QI's enrollment on the date coverage became effective resulting in coverage never having been effective, [noting that the termination transaction may include a termination or end date of the day before (11:59PM) the effective date of coverage]. Cancellations can be initiated by the issuer or the QI.

A QI may choose to cancel coverage prior to the coverage effective date for any reason (and in certain states, during a free look period). For instance, the QI may no longer want or need health insurance coverage through the FFEs because he or she gained other coverage. Or, the QI may have changed their mind within an enrollment period about the QHP or QDP he or she selected, and therefore, wishes to select a different available QHP or QDP.

Cancellation transactions initiated by the QI are voluntary and the associated request must generally be made at the Marketplace Call Center. Because the FFEs cannot automatically cancel a passive reenrollment if the enrollee actively reenrolls via a disconnected application (either directly or through an assister), enrollee cancellation requests to issuers for passive reenrollments (policy origin = 11) that are still in passive status (no active plan selection has been completed) are the exception. Issuers are therefore expected to process cancellation requests received directly from the QI for passive reenrollments. Issuers should report the cancellation via IC834 or monthly reconciliation.

A QI must complete submission of their cancellation request to the FFE by 11:59 PM ET on the date prior to the coverage effective date. A QI who enrolled through the FFEs cannot request a cancellation after their coverage effective date unless the enrollee is in a free look period), or another basis under 45 CFR §155.430(b)(1)(vi)(B) or (C) applies. The QI may elect to cancel enrollment in a QHP or QDP and select a different available QHP or QDP, as many times as he or she chooses within an enrollment period, as long as the QI completes submission of the cancellation request prior to the coverage effective date.

QHP and QDP issuers in the FFEs may initiate a cancellation transaction due to non-payment of the binder payment by the QI. CMS expects QHP and QDP issuers to transmit cancellation transactions to the FFEs without undue delay (no more than 48 hours after updating the policy to a cancelled status in the issuer's system).

NOTE: Issuers that receive a HICS case to cancel a passive reenrollment (policy origin = 11) should cancel the passive auto-reenrollment.

Active policies must be cancelled or terminated by the enrollee through the Exchange unless there is a HICS case noting an enrollment blocker. However, if an enrollee makes a change to a passive enrollment via M834 (policy origin other than 11), the enrollment is considered an active selection.

2.3.3.1 Examples

Example 2C: A QI selects a QHP on December 12 and therefore is assigned a coverage effective date of January 1. The full monthly premium for the selected plan is \$300 and the issuer does not make use of a premium payment threshold. The enrollee is qualified for a maximum APTC of \$125 per month. The enrollee elects to receive the full APTC amount of \$125. Therefore, the 834 enrollment

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transaction indicates the full monthly premium of \$300, which includes the monthly APTC amount of \$125 and the \$175 enrollee-responsible portion of the monthly premium. The issuer established a premium payment deadline of 30 days from the coverage effective date.

The enrollee mails the \$175 payment on January 30. The issuer does not receive the payment until February 3. The issuer should send the FFEs an IC834 cancellation transaction without undue delay and refund the QI \$175 since the payment was not received prior to the effective coverage date. Furthermore, the issuer must set the cancellation end date on the IC834 to January 1 as any date after January 1 would indicate a period of active coverage for the policy.

Additionally, CMS will recoup any APTC paid to the QHP or QDP issuer and adjust user fees for that enrollee. The issuer should report the cancellation to the FFEs during the monthly enrollment data reconciliation.

Example 2D: Circumstances are the same as Example 2C except the enrollee mails a payment of \$100 but does so on December 16, and the issuer has established a premium payment deadline of the effective date of coverage. The issuer receives the payment on December 18. The enrollee makes no further payment towards the initial month's premium. Although payment was received by the issuer prior to the coverage effective date, because the enrollee did not make payment in full, the issuer cannot effectuate enrollment by sending the confirmation file. No coverage is effectuated on January 1, and the issuer should send the FFEs the IC834 cancellation transaction without undue delay and refund the QI \$100. Once again, the issuer must set the cancellation end date on the IC834 to January 1, as any later date would indicate a period of active coverage for the policy. Any APTC paid on the behalf of the QI must be returned to the FFEs.

2.3.4 Fraud Cancels Related to Approved Rescissions and Unauthorized Enrollments

FFE policies may be cancelled when CMS has approved the issuer's request to rescind the enrollment because it is satisfied that the issuer has demonstrated that the rescission is appropriate. For example, if an enrollment was made without the subscriber's authorization, and the issuer has found no evidence that the subscriber was aware of the enrollment ("unauthorized enrollments"), the issuer may be able to demonstrate that a rescission is appropriate.

Additionally, if the issuer is able to demonstrate to the satisfaction of the Exchange that the enrollee, or person acting on their behalf, made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage, the issuer may also be able to rescind the enrollment.

For tracking purposes, issuers should send the FFE an **IC834 cancel transaction** for current year policies with a reason code of fraud using the **CANCEL-FRD** AMRC. For intentional misrepresentation of material fact, as prohibited by the terms of the plan, issuers should use the **CANCEL-RESCIND** AMRC if notified that CMS has approved their rescission request (in both instances, issuers should always use a CANCEL and not a TERMINATION transaction). Issuers should be aware that policies for prior plan years will still be accepted through IC834 until the annual cut-off is implemented (typically late Summer but is subject to change each plan year). After the deadline, prior year policies cannot be cancelled via IC834, so an issuer will need to submit an Enrollment Resolution and Reconciliation (ER&R) dispute, setting "Prior Year – End Date" to equal the start date of the policy (as of the time of publication, cancel reason can only be recorded in IC834, and not in reconciliation or ER&R).

For additional information on rescissions and unauthorized enrollments see Section 13.

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2.3.5 Free Look Provisions in the Individual Market FFEs (Applicable to QHPs/QDPs)

Certain states have laws that provide a QI in health insurance coverage a free look period. These provisions allow an enrollee to retroactively cancel coverage in a QHP or QDP in the FFEs, within a certain period of time.

In states with laws providing for a free look period, an enrollee in an FFE may request cancellation of coverage in their QHP and QDP after their coverage effective date after first terminating their coverage through the FFE. Since rules can vary by state, QHP and QDP issuers may initiate free look cancellations as long as the requests from enrollees are consistent with applicable state laws. Issuers are encouraged to use the AMRC for “free look” cancels pursuant to the 834 Companion Guide described earlier in this section.

Premium refund policy in the case of free look cancellations follows existing state-specific guidelines. Generally, if an enrollee’s request to cancel coverage under a free look provision meets all required criteria, the QHP or QDP issuer must return any premium paid by the enrollee.

Additionally, CMS will recoup any APTC paid to the QHP or QDP issuer and adjust user fees for that enrollee. The issuer should report the cancellation to the FFEs during the monthly enrollment data reconciliation. CMS will not initiate an enrollment cancellation through an 834 or through HICS as the result of a QI seeking a cancellation under free look provisions.

If a QI cancels their QHP or QDP coverage during OEP, the QI may select a new QHP or QDP. Cancellation under a free look period does not qualify the enrollee for an SEP for loss of minimum essential coverage (MEC).

2.3.5.1 Examples

Example 2E: In the FFEs, a QI residing in a state with a free look period selects a QHP on December 5 with a coverage effective date of January 1. The enrollee takes the necessary actions that would qualify him or her for a free look cancellation within 30 days of coverage from the start of coverage under state law. On January 30, the enrollee requests cancellation under the free look law from the enrollee’s QHP issuer. The QHP issuer processes the request with a cancellation date of January 1.

The QI may return to the FFEs to select new coverage as long as he or she qualifies for an SEP. The QI is not eligible for an SEP as a result of the cancellation of his Exchange coverage.

Example 2F: In the FFEs, a QI who is eligible for an SEP and who is residing in a state with a free look period selects a QHP on January 5 with a coverage effective date of February 1. The enrollee takes the necessary actions that would qualify him or her for a free look cancellation within 30 days of coverage from the start of coverage under state law. On February 28, the enrollee requests cancellation under the free look provision from the enrollee’s QHP issuer. The QHP issuer processes the request with a cancellation date of February 1. The QI is not eligible for another SEP as a result of the cancellation of his Exchange coverage.

To enroll in coverage through the FFEs, the QI must wait until the next OEP or must qualify for an SEP, as provided in 45 CFR §155.420.

2.4 Application and Enrollment Changes

In accordance with 45 CFR §155.330(b), and as specified in 45 CFR §155.305, enrollees and tax filers are required to report changes to information on their applications no later than 30 days after the

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changes happen. These changes can be reported to the FFEs via internet or by calling the Marketplace Call Center.

Some updates reported by the enrollee may result in changes to an enrollee's eligibility for coverage or financial assistance through the FFEs, or may qualify the enrollee for an SEP. If changes are not reported, the tax filer may be liable to repay some or all of the APTC received during the year.

Issuers should instruct enrollees to follow the process for reporting changes through the FFEs provided in **Exhibit 8**.

Exhibit 8: Process for Reporting Changes

Step	Process
1	The QI logs in to their account and selects the "Report a Life Change" button. (This button is enabled only for QIs who have a current year application.)
2	The QI lands on a page with information about the types of changes that must be reported to the Marketplace. The next screen allows the QI to change household eligibility information, make changes to notification preferences, or report a move to a new state.
3	If the QI reports changes that may affect eligibility, an updated copy of their application is created, pre-populating some information and attestations from their earlier application.
4	The QI updates the application and answers questions that determine whether the (new) applicants are or (existing QI) are still eligible for QHP or QDP enrollment through the FFEs (and financial assistance if requested), and if so, whether the new information triggers an SEP.
5	If a QI is eligible for an SEP, the QI's eligibility determination notice contains SEP eligibility language.
6	If any applicants for whom new information is being provided are eligible to enroll in a QHP/QDP through a Marketplace (i.e., they are QIs), the QI proceeds to the enrollment to-do list page to finish QHP and/or QDP enrollment(s) for all QIs on the application.
6a	If new information is being provided for an applicant based on an event that triggers an SEP, all QIs on the application have the ability to compare and select from QHPs and QDPs available in their service area under the plan category restrictions for the corresponding SEP(s).
6b	If the new information provided does not trigger an SEP, the QI will be limited to selecting the QHP or QDP in which he or she is currently enrolled. This non-SEP selection will provide QHP/QDP with the updated enrollment information.
7	The QI eligible for an SEP sets the amount of APTC the tax household will use and selects a new plan (or the existing plan, depending on the situation).
8	Once the QI eligible for an SEP selects a plan, the system will generate enrollment transactions to the issuer as appropriate based on the plan selected. <ul style="list-style-type: none"> • Updates that maintain the same subscriber and the same FFE Policy ID will be sent as a Maintenance (M834) transaction • Updates that change the subscriber or QHP/QDP ID will change the FFE Policy ID and thus be sent as a Change in Circumstance (CIC) transaction

In some limited cases, in addition to reporting the change on an application, the enrollee may need to submit a new application to enroll in coverage. The enrollee should create a new application when the enrollee has moved to a new state or when the enrollee will no longer be on the same federal income tax return as the other enrollees on the current application (such as due to a divorce or when a young adult will no longer be claimed as a tax dependent by their parents). When this occurs outside the OEP, the enrollee could qualify for an SEP based on the loss of their previous Marketplace coverage

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or based on gaining access to new QHPs as a result of a permanent move. However, in general, QIs do not need to create a new application or user account in order to report a change.

Exhibit 9 provides a list of reportable changes. Enrollees can also report changes during the annual eligibility redetermination. For more information on the redetermination process, see Section 3, Redeterminations and Renewals.

Exhibit 9: Reportable Changes

Change Type*	Where to Report
Increase or decrease in projected annual household income for the coverage year or change to current month's household income	FFEs
Add or remove applicant or non-applicant household member listed on application (such as whenever there is a birth, death, or marriage)	FFEs
Relocation/change of address to a new ZIP Code or county	FFEs
Gain or loss of other health coverage	FFEs
Pregnancy (may affect Medicaid eligibility under applicable state rules)	FFEs
Change in full-time student status for 18-22-year-olds (could affect Medicaid eligibility under applicable state rules)	FFEs
Becoming the primary caretaker for a child living with you (could affect Medicaid eligibility under applicable state rules)	FFEs
Change in tax filing status (e.g., will or will not file, joint or separate filer) or change in tax dependents that will be claimed	FFEs
Newly incarcerated or released from incarceration	FFEs
Change in immigration status or citizenship	FFEs
Change in status as member of federally recognized tribe	FFEs
Became disabled or in need of long-term care (or is no longer in need of long-term care)	FFEs
Change to available employer coverage	FFEs
Change in enrollment in other health coverage	FFEs
Correct/update the relationships between family members	FFEs

*For information on whether reported changes are classified as financial or demographic, please refer to Section 2.2 of the M834 Operations Manual, which can be found at

<https://zone.cms.gov/document/federally-facilitated-marketplace-maintenance-834-operations-manual>.

3. REDETERMINATIONS AND RENEWALS IN THE INDIVIDUAL MARKET FFEs (ANNUAL OPEN ENROLLMENT)

3.1 Introduction

Pursuant to 45 CFR §155.335, an Exchange has the flexibility to conduct annual redeterminations using either the procedures described in 45 CFR §155.335(b) through (m), alternative procedures specified by the Secretary for the applicable plan year, or alternative procedures approved by the Secretary based on a showing by the Exchange that such procedures meet specified criteria. The alternative procedures utilized by the Federally-Facilitated Exchanges (FFEs) are published as written guidance on redetermination and reenrollment on the CCIIO website.⁴

For each plan year, the FFEs will provide a Marketplace Open Enrollment Notice (MOEN) to all qualified individuals (QIs) currently enrolled in Qualified Health Plans/Qualified Dental Plans (QHPs/QDPs) through the FFEs in advance of the Open Enrollment Period (OEP) for future plan year coverage. This notice is focused on announcing the OEP, and contains other basic information, including a description of the annual redetermination and renewal process, the requirement to report changes affecting eligibility and the channels for reporting such changes, and the last day plan selections may be made for coverage starting on January 1 of the upcoming plan year. For enrollees who authorized the FFEs to request updated tax return information for use in the annual redetermination process and who are receiving advance payments of the premium tax credit (APTC) or income-based cost-sharing reduction (CSR), this notice will have information on the APTC reconciliation process. Information specific to the enrollment, such as the future year premium, and any financial assistance (possibly initially estimated), will come from the issuer's renewal or discontinuation notice, supplementary notice, and/or January invoice.

MOENs will contain special messaging for QIs who are at risk for having their APTC discontinued in the new coverage year. These groups include the following:

1. **Special Notice Group:** Consists of QIs enrolled in a QHP with APTC or income-based CSR, and are determined by the FFEs to have a household income above 500% of the Federal Poverty Level (FPL)⁵ based on updated tax return information and family size.
2. **Opt-Out Group:** Consists of QIs enrolled in a QHP with APTC or income-based CSR who did not authorize the FFEs to request updated tax return information for the purpose of annual redetermination, or the QI's authorization has expired.
3. **Failure to File and Reconcile Group (FTR):** Consists of QIs enrolled in a QHP with APTC or income-based CSR to whom APTC was provided in a past year, and whose tax filer(s) did not comply with the tax filing and APTC reconciliation requirement for that year under 45 CFR §155.305(f)(4) according to Internal Revenue Service (IRS) data.

⁴ For example, for the 2019 Plan Year, the annual redetermination/reenrollment guidance was published July 6, 2018, at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Enrollment-ARR-Guidance.pdf>

⁵ Federal Poverty Level: A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine an individual's eligibility for certain programs and benefits, including saving on Exchange health insurance and Medicaid/CHIP coverage. Since 2006, the poverty guidelines have been published in late January, with the exception of 2010. To view the latest FPL, visit <https://aspe.hhs.gov/poverty-guidelines>.

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4. Repeat Passive Re-enrollees (RPR): Consists of QIs who were automatically re-enrolled with APTC or income-based CSR for the past two consecutive coverage years and have no tax data (meaning, no income or FTR indicator) available from the IRS for the previous two relevant tax years.

Notices for these groups will state the same information as the standard notice, along with an explanation that the FFEs strongly encourage enrollees receiving APTC or CSR to contact the FFE to obtain an updated eligibility determination from the FFE and make a plan selection by the last day of plan selection for a January 1 coverage effective date, as specified in 45 CFR§155.410(f).

For examples of MOENs, see Marketplace Open Enrollment and Annual Redetermination Notices at <https://marketplace.cms.gov/applications-and-forms/notices.html>

For a QI who is at risk of losing financial assistance and does not contact the FFEs to obtain an updated eligibility determination and select a QHP by December 15, the FFEs will establish future year eligibility based on a hierarchy of the most recent income data available and reenroll the QI in QHP coverage without APTC or CSR. The FFEs may use either IRS data or verified QI-provided application data, which is verified either through electronic data sources (EDSs) or a manual documentation submission process, whichever is most recent. This income data, together with updated FPL tables and benchmark plan premium information, is used to update eligibility for APTC and CSR.

3.2 Reenrollment

Reenrollment is the general term used to describe coverage continued into a new plan year, whether the next plan year's coverage is under the same or different "product" (as defined in 45 CFR §144.103), or with a different issuer. Reenrollment for the next plan year can be either "active" or "passive."

3.2.1 Active Reenrollment

An active reenrollment is initiated by an enrollee returning to the FFEs during the OEP to submit an application and select a plan for the next plan year. It is important that current FFE enrollees who are seeking to actively reenroll access their HealthCare.gov accounts to update their eligibility information and make plan selections. This provides enrollees with pre-populated applications and helps the FFEs and issuers maintain continuity in enrollments. Tips for enrollees who have trouble logging into their HealthCare.gov account are available at <https://www.healthcare.gov/help/i-am-having-trouble-logging-in-to-my-marketplace-account/>.

Note that it is very important for enrollees or their Agents or Brokers (A/Bs) to access their respective existing Exchange accounts, so they can receive a pre-populated eligibility application for the future plan year. This allows the Exchange to accurately connect the future year enrollment with the current year enrollment. Failure to use a pre-populated application to enroll in future year coverage may lead to duplicate enrollments and QI confusion.

Prior to assisting a QI, the A/B should determine whether the QI has an existing application to avoid creating more than one application for the same QI. Failure to follow these steps can create confusion for the enrollee as well as the issuer, as duplicate enrollments may be created if an existing enrollee's pre-populated future year application is not accessed.

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To prevent unnecessary creation of a new application, the A/B application search was updated to enhance the enrollment experience. Updates include: pulling both current and future year application when the A/B searches for the current year application, preventing an A/B from pre-populating a future year application using a current year application, when a future year application already exists, and only displaying an application with an active policy for a given year, when one is available.

3.2.2 Passive Reenrollment/Batch Auto-Reenrollment

Passive reenrollment, also called auto-reenrollment or Batch Auto-Reenrollment (BAR), is the process that the FFEs use to reenroll current enrollees who do not return to the FFEs to submit an application and select a plan by December 15 to help ensure that they can have coverage on January 1 of the following year.

Issuers indicate next year's auto-reenrollment plan as determined under 45 CFR §155.335(j) to the FFEs on the Plan ID Crosswalk Template in current year Plan ID/service area combinations. The Plan ID Crosswalk is submitted by the issuer with other plan materials during the QHP certification process. The FFEs use the Plan ID Crosswalk Template to conduct the passive reenrollments.

Auto-reenrollment will run as follows:

- **October Wave** (approximate start in mid-Oct): All Enrollees eligible for renewal who are being reenrolled into a plan offered by the same issuer or matched to an alternate plan from a different issuer by CMS or a State Insurance Department, as applicable. Goal is to complete by November 1.
- **Incremental Wave** (approximate start in late Nov/early Dec): New current year enrollees who enrolled after earlier October BAR; enrollees whose auto-reenrollment is being updated because the enrollee or an Exchange reported new eligibility information for the current year after October BAR.
- **December Wave** (approximate start in mid-Dec): New current year enrollees who enrolled after November BAR; enrollees whose auto-reenrollment is being updated because the enrollee or an Exchange reported new eligibility information for the current year after November BAR.

Most passive reenrollment transactions are sent to issuers before the start of the OEP to provide issuers time to prepare issuer-provided reenrollment notices, which identify the reenrollment plan and include information about any APTC that will be provided if the QI is auto-reenrolled. Enrollees who visit HealthCare.gov and check their Marketplace accounts during the OEP will not see their passive reenrollment until December 16, though once they are determined eligible to enroll in a QHP through the Exchange and proceed to plan selection, they will see the reenrollment plan pre-selected for their convenience.

Issuers may communicate with QIs regarding these reenrollment transactions but should not send an invoice for future year coverage until after the OEP starts. An enrollee has until December 31 to indicate to the Exchange that they don't want to be auto-reenrolled by opting out of passive reenrollment through BAR on HealthCare.gov. Confirming "stop coverage for (future year)" will send a current year policy termination that day, effective December 31, and simultaneously cancel the future year BAR policy (if already sent; if not yet sent the policy will not be auto-renewed).

For passive reenrollments, issuers must reenroll an enrollee in a QHP in accordance with the BAR reenrollment transactions sent, which follow the hierarchy described at 45 CFR §155.335(j). This generally requires that an enrollee be renewed in the same QHP, if available, or a plan in the same

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product, if available through the Exchange. If no plan in the same product is available through the Exchange, the issuer may reenroll the enrollee into a different product available through the Exchange. With regard to enrollees in silver level QHPs, if an enrollee's current silver level QHP is not available and the enrollee's current product no longer includes a silver level QHP available to the enrollee through the Exchange, the enrollee's would be reenrolled in a silver level QHP in the product offered by the same issuer that is the most similar to the enrollee's current product, rather than in a plan one metal level higher or lower than their current silver level QHP, but within the same product.

If an enrollee hasn't yet been passively reenrolled and makes an active plan selection, they will not be passively reenrolled through BAR. Additionally, active plan selections through December 15 automatically cancel or update any auto-reenrollment already sent for the enrollee. If an enrollee updates their current plan year coverage after he or she was passively reenrolled for the next plan year, those changes generally will be carried forward to the next plan year policy through the December BAR process. However, if an enrollee makes an active update to their next plan year's policy, subsequent updates to current plan year coverage will not be automatically carried forward to the next plan year's policy through the December BAR process. Absent a special enrollment period (SEP) (such as Loss of Coverage due to current year issuer discontinuing coverage), active plan selections cease December 15. If the enrollee makes an active plan selection before December 15, any passive reenrollment transaction previously sent by the FFEs should be disregarded, even if received out of sequence. A QI can make an election at any time during the OEP or during an SEP, even if a previous passive or active reenrollment has been effectuated. The new coverage starts in accordance with normal effective dates, unless an enrollee has an SEP that allows for non-standard effective dates.

3.2.3 BAR Operational Process

- CMS selects application with a current, active enrollment.
- CMS pre-populates a future plan year application; this application is not visible to the enrollee until the returning enrollee logs into their Marketplace account on or after the first day of OEP.
- CMS creates a future plan year enrollment using the Plan ID Crosswalk Template provided by the issuer, or in an alternate plan from a different issuer (see Section 3.2.4, Alternate Enrollments). This enrollment will not be visible to the QI until the end of OEP, and only if the QI does not actively select a plan for the upcoming plan year.
- CMS sends the enrollment transaction to the issuer.
- CMS repeats steps 1–4 for Incremental Wave and December Wave.
- CMS generates an eligibility determination notice and enrollment confirmation message for enrollees who did not make an active plan selection by the last day of OEP.

3.2.4 Alternate Enrollments

Where no QHP from the same issuer is available to enrollees through the Exchange, then to the extent permitted by applicable State law, the Exchange directs alternate enrollments for such enrollees into a QHP from a different issuer. This process doesn't apply to QDPs or plans in the Small Business Health Options Program Exchanges (SHOPs).

In such cases, reenrollments are conducted as directed by the applicable State regulatory authority. If the applicable State's regulatory authority declines to act, to the extent permitted by applicable State law, the Exchange may reenroll the affected enrollee in a similar QHP from a different issuer with a service area that covers the enrollee's location, taking into account the issuer's ability to absorb new

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enrollment and the lowest premium plan, according to the following hierarchy, which prioritizes finding a policy offered by a different issuer that is similar to the enrollee's current coverage.

- The enrollee's coverage will be auto re-enrolled in a QHP at the same metal level under the same product network type.
- If there is no QHP available at the same metal level under the same product network type in the same service area, the enrollee will be auto re-enrolled in a QHP at the same metal level under a different, if possible similar, product network type.
- If no QHP is available from the same metal level under a different product network type in the same service area, the enrollee will be auto re-enrolled in a QHP that is one metal level lower than the enrollee's current QHP under the same product network type.
- If no QHP is available that is one metal level lower than the enrollee's current QHP under the same product network type in the same service area, the enrollee will be auto re-enrolled in a QHP that is one metal level lower under a different, if possible similar, product network type.
- If no QHP is available that is one metal level lower under a different product network type in the same service area, the enrollee will be auto re-enrolled in a QHP that is one metal level higher than the enrollee's current QHP under the same product network type.
- If no QHP is available that is one metal level higher than the enrollee's current QHP under the same product network type in the same service area, the enrollee will be auto re-enrolled in a QHP that is one metal level higher under a different if possible similar, product network type.
- If no QHP is available that is one metal level higher under a different product network type in the same service area, the enrollee will be auto re-enrolled in a QHP at any metal level under the same product network type.
- If no QHP is available for enrollment at any metal level under the same product network type in the same service area, the enrollee will be auto re-enrolled in a QHP at any metal level under a different, if possible similar, product network type.

The Exchange sends this type of auto-reenrollments to the new future plan year issuer as initial enrollments, with an Electronic Fund Transfer (EFT) code of I834, and Additional Maintenance Reason Code (AMRC) of PASSIVE – NEW TO ISSUER, in contrast to other passive reenrollments, which are sent with an EFT code of I834AR. For a smoother enrollment experience, we encourage alternate enrollees who wish to change plans to enroll by December 15, though they are generally eligible for an accelerated SEP permitting plan changes until December 31.

3.2.5 Reenrollment Communications to Enrollees

In addition to the MOEN sent by the Exchange, issuers are also required to send notices of product renewal and discontinuation to current enrollees as specified in 45 CFR §§147.106 and 156.1255. An issuer must provide to each individual market policyholder written notice of renewal before the first day of the next annual OEP. For more information on federal standard notices of product discontinuation and renewal in connection with the OEP, see the latest CMS guidance (as of this document's publication date, see <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updtd-Standard-Renewal-Product-Discontinuation-Notices.pdf>).

Finally, if the enrollee has not returned to the Exchange to make an active selection for the next plan year by December 15, the Marketplace will send both an updated Eligibility Determination Notice (EDN) and an Enrollment Confirmation Message to the enrollee. These notices inform the enrollee of their eligibility determination for the upcoming plan year and of their passive reenrollment status. The

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Enrollment Confirmation Message notes whether the enrollees on the relevant application were successfully reenrolled. If the enrollees were reenrolled, the confirmation message indicates the plan name(s), Plan ID(s), and information about any financial assistance that was applied. If the QIs were not reenrolled (because the coverage was discontinued by the issuer, or the enrollees on the application are not eligible for passive reenrollment), QIs will not receive an Eligibility Determination Notice, but are notified in the Enrollment Confirmation Message of their failure to auto-renew and are encouraged to actively complete applications and plan selections through the FFEs. If the BAR fails, the Exchange does not generate EDNs because the EDN is dependent on all QIs on the application enrolling in coverage.

3.2.6 BAR Failure Report to Issuers

As in previous years, there are some BAR transactions that cannot be processed due to technical issues. This is a very small portion of all applications. For those BAR transactions that are unsuccessful due to technical issues, a BAR Failure report is sent to the affected issuers. Therefore, not all issuers will receive this file. The BAR Failure report generally is sent in late December or early January of the coverage year.

The BAR Failure report is delivered to impacted issuers in the EFT IOUTrC format. Issuers are encouraged to use this file for voluntary outreach to enrollees; the goal is for the enrollee to actively re-enroll through the FFEs. This file contains enrollee contact information. Enrollees contained in the BAR Failure report sent to issuers are eligible for a 60-day SEP. The Marketplace Call Center flags these enrollments for optional January 1st effective dates if the enrollee actively returns to the FFEs and makes a plan selection by March 1. The Exchange will also conduct outreach to these flagged enrollees. When these flagged enrollees contact the Marketplace Call Center, they may enroll in future year coverage with either a prospective date or a retroactive effective date of January 1st. In both of these scenarios, the 834 will have a prospective date. If the consumer elected a retroactive effective date to January 1st, a Health Insurance Casework System (HICS) case will be opened by the Marketplace Call Center.

3.3 Enrollment Transaction Types

Active reenrollments for the future plan year's coverage are sent in daily batches as 834 initial enrollments to issuers according to current FFE procedures. Since the FFEs auto-reenroll members before OE begins, most active reenrollments are sent as Maintenance (M834) transactions. Active reenrollment 834 transactions sent to issuers also include plan selection changes made within the new plan year, such as when an enrollee replaces future year Plan A with future year Plan B during the OEP. Plan selection changes are sent as a cancel/term transaction to the first plan, and an initial enrollment transaction to the gaining plan (plan selection changes are not sent as a Maintenance/M834 transaction).

Regular Change in Circumstance (CIC) transactions where enrollees report a change to their application information for either current or next year's coverage during the OEP, such as updating income, reporting a new phone number, or adding a new family member, are sent according to existing procedures.⁶

⁶ For specific transactional information about CICs performed on current year policies, please refer to Section 2.2 of the FFEs Maintenance 834 Operations Manual. <https://zone.cms.gov/document/federally-facilitated-marketplace-maintenance-834-operations-manual>

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The FFEs send passive reenrollment transactions as part of the BAR process described in Section 3.2.2. There are three populations for which an issuer may receive updates made after the initial auto-reenrollment. The updates will be sent to issuers via maintenance 834 transactions in the second wave of BAR in December.

1. The first population is comprised of enrollments that report a current year CIC after being auto-reenrolled for the future year. The maintenance 834 transaction updates the future year plan to include the eligibility update made in the current year CIC.
2. The second population is made up of auto-reenrollments that later submitted an active future year application but did not complete an active future year plan selection. The maintenance 834 transaction updates the future year enrollment with the eligibility information reported in the active future year enrollment.
3. The third group includes enrollments initially batch auto-reenrolled without financial assistance because records indicated that they received APTC for a prior plan year and initially failed to file a tax return, then subsequently met the tax filing requirement, as confirmed by the IRS. This group may have financial assistance restored in the second wave of BAR via a maintenance 834 transaction.

Passive reenrollments other than alternate enrollments with new issuers are initial enrollment transactions with a Maintenance Type Code (INS03) of 021 “Addition,” and a Maintenance Reason Code (INS04) of 41, with an AMRC that signals that it is an auto-reenrollment in either effectuated or initial status. All passive reenrollments have an effective date of January 1, and most are sent with EFT Functional Code of I834AR, though alternate enrollments are sent EFT I834. **Exhibit 10** provides a table of passive reenrollments and their associated Maintenance Type Code, Maintenance Reason Code, Origin Type, and AMRC.

Exhibit 10: Passive Reenrollment Codes

Grouping	MTC	MRC Sent/ Rec'd	Origin Type	AMRC	Binder Required/Issuer Confirms Effectuation	EFT Functional Code
BAR Effectuated	021	41/NA	11	PASSIVE	N	I834AR
BAR Initial	021	41/28	11	PASSIVE - INITIAL	N	I834AR
BAR New Subscribers (e.g., young adults who have aged-out as dependents by year end and are being reenrolled as a subscriber)	021	41/28	11	PASSIVE - NEW SUBSCRIBER	Y	I834AR
BAR New Issuer, (i.e., enrollee who is auto-reenrolled by CMS because no plans are available to enrollee from current year issuer)	021	EC/28	11	PASSIVE REENROLL - NEW TO ISSUER	Y	I834

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Issuers should not continue enrollments through the Exchange into the future plan year unless the issuer receives an 834 enrollment transaction from the FFEs or finds the enrollment listed on a future year Pre-Audit File or in the Get Enrollment real time Application Programming Interface (API). The vast majority of active reenrollments for QIs who keep their reenrollment plan are sent as 834 maintenance transactions since the FFEs send BAR transactions before the OEP. If re-enrollees update their future year application and keep the same 14-character Plan ID, removing or changing the subscriber would mean the update was sent as a CANCELIC cancellation.

The FFEs send CANCELIC cancellations for any passive reenrollments for enrollees who subsequently change Plan IDs during active plan selections before December 15. An initial enrollment is sent to the issuer of the new plan selected by the QI through an active plan selection, which includes eligibility updates, if applicable. An issuer that receives a cancellation of the passive reenrollment should not renew the enrollment unless the enrollee has actively renewed coverage with the issuer, causing an active reenrollment transaction to be sent. For most enrollments for enrollees who have been passively reenrolled, but then make a plan selection change with an effective date after January 1, the FFEs will terminate their passive reenrollment effective the day before the actively selected plan becomes effective. For example, an enrollee eligible for a Loss of MEC (minimum essential coverage) SEP because the current year product is no longer available to them may make a plan selection change (SEP ending March 1) on January 2; the issuer of the auto-reenrolled policy would receive a termination effective January 31, and the issuer of the newly selected plan would receive a February 1 enrollment. In no case does a plan selection for the future plan year send a termination to the current year issuer for current year coverage.

For enrollees who actively reenroll for the next plan year before the FFEs send auto-reenrollment transactions for them, the FFEs will not send a passive reenrollment transaction. If the enrollee who has not been batch auto-reenrolled actively enrolls with a different issuer for the next plan year, the Exchange will list the subscriber on electronic “Switch Files” sent daily from the beginning of OEP to mid-December to the enrollee’s current issuers. This list of current year subscribers who have actively “switched” issuers for the next plan year is provided so current year issuers know to non-renew the listed subscribers’ enrollments (see Section 3.4.1, Enrollee Switch File, for additional information).

3.3.1 Identifiers on Enrollment Transactions

- FFE-assigned Subscriber ID and Member ID, also known as Exchange AssignedSubscriber ID and Exchange Assigned Member ID, remain the same for enrollees choosing the same issuer (i.e., five-digit Health Insurance Oversight System [HIOS] ID) for the next plan year.
- FFE Application IDs and FFE policy numbers are new for all next year plan selections, whether active or passive.
- The FFEs aim to send issuer-assigned identifiers on reenrollments.
- An A/B National Producer Number (NPN), if recorded on the current plan year application, will be sent on passive reenrollments. For an active reenrollment, the NPN from the current year will be pre-populated on the next year application (if the NPN is already associated with the current year application) but may be removed or edited by the applicant. **Exhibit 11** illustrates the rules governing how to send NPNs.
- Information for assisters who are not A/Bs is not sent on passive reenrollments.
- Assister information for all types (e.g., Navigators, Certified Application Counselors [CACs]) will be sent on active reenrollments according to existing procedures.

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Exhibit 11: NPN Rules

NPN Scenarios	NPN on Current Year Enrollment	NPN Sent on 1000c Loop on Next Year 834 Enrollment Transaction
Auto-reenrolled (passive) QI with FFE Policy associated with NPN before mid-October	123	123
Auto-reenrolled (passive) QI with FFE Policy updated with NPN after the enrollee has been auto-reenrolled	123	N/A (at the time BAR auto-renewed the member, there was no NPN to carry forward)*
Active reenrollment by returning QI who updates the next year application, and is able to view and edit the current year A/B, but doesn't change or remove the A/B associated with their application	456	456 (The A/B info from the current year application will be pre-populated on the next year application)**
Active reenrollment by returning QI who removes the A/B information on their next year application	789	N/A. A QI can remove the A/B info on the future year application.

* **NOTE:** NPNs received post BAR Wave 1 via Recon will be relayed to issuers in BAR Wave 2.

** **NOTE:** If the most recent version of the QI's current year application includes the NPN, the NPN will pre-populate on the future year application; the NPN will not pre-populate if it is not included on the most recent version of the current year application. This is particularly important for DE Entities using the DE QI Flow, who only submit the NPN via the Submit Enrollment Request but do not include it on the application itself. NPNs submitted via the Submit Enrollment Request are only written to the QI's policy, but not the application. This highlights the importance of DE Entities assisting their clients with the reenrollment process.

Exhibit 12 illustrates reenrollment transaction scenarios and their associated 834 maintenance reason code, FFE subscriber IDs, and whether effectuation is sent to the FFEs.

Exhibit 12: Reenrollment Transaction Illustration

Scenario	834 Maintenance Reason Code	FFE Subscriber ID (Next Year vs. Current Year)	New Policy ID/App ID Assigned? (Next Year vs. Current Year)	Send Effectuation to FFEs?	Collect Binder from Enrollee?
Auto-reenrollment (passive) – A current enrollee does not return to the FFEs to update eligibility and plan selection. Their coverage is renewed by the issuer as indicated on the Plan ID Crosswalk Template.	INSO4: 41	Same	Yes/Yes	No	No

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Scenario	834 Maintenance Reason Code	FFE Subscriber ID (Next Year vs. Current Year)	New Policy ID/App ID Assigned? (Next Year vs. Current Year)	Send Effectuation to FFEs?	Collect Binder from Enrollee?
Active reenrollment – A current enrollee returns to the FFE by December 15 to actively apply and enroll in next year coverage. The enrollee’s next year selection is the same product as the current year’s product. The enrollee’s passive reenrollment is cancelled by the FFE when it sends the initial enrollment.	INSO4: EC	Same	Yes/Yes	No	No
Active switch after auto-enrollment – A current enrollee actively applies at the FFE and enrolls with a different issuer by December 15. The enrollee’s passive reenrollment is cancelled by the FFE. Since the enrollee switched to a different issuer, the enrollee will also appear on Switch File, ⁷ so the current year issuer will non-renew the enrollee’s coverage.	INSO4: EC	New	Yes/Yes	Yes	Yes
Active switch before auto-reenrollment – A current enrollee actively enrolls with a different issuer on November 1, before the enrollee was passively reenrolled. The FFE will not send a passive reenrollment because the enrollee is already actively enrolled, thus there is no passive reenrollment for the FFE to cancel. However, the enrollee will appear on the Switch File, so the current year issuer will non-renew their coverage.	INSO4: EC	New	Yes/Yes	Yes	Yes

⁷ The Switch File is an electronic file delivered separately for each issuer offering plans through the FFEs to identify the issuer’s current subscribers who have actively reenrolled in next year coverage offered by a different issuer.

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Scenario	834 Maintenance Reason Code	FFE Subscriber ID (Next Year vs. Current Year)	New Policy ID/App ID Assigned? (Next Year vs. Current Year)	Send Effectuation to FFEs?	Collect Binder from Enrollee?
Blended (passive, then active CIC during OEP) – A current enrollee is passively reenrolled effective January 1 during BAR Wave 1. Because the enrollee was in the special notice group and failed to update their eligibility information, the QI is enrolled with zero APTC. On December 14, the enrollee actively returns to report updated eligibility information via a CIC and is determined eligible for APTC, reselecting the same plan, with the updated information taking effect January 1. The FFE sends a cancellation of the passive reenrollment, then a January 1 initial 834 reflecting the update.	<ul style="list-style-type: none"> January 1 initial (no APTC): INSO4: 14 (Cancel) 	Same	Yes/Yes	No	No
	<ul style="list-style-type: none"> January 1 during BAR January 1 initial (with APTC): INSO4: EC 	Same	Yes/Yes	No	No
Blended (passive, then active CIC after OEP) – A current enrollee is passively enrolled effective January 1 during BAR Wave 1. Because the enrollee was in the special notice group and failed to update their eligibility information, the QI is enrolled with zero APTC. On December 18, the enrollee actively returns to report updated eligibility information via a CIC and is determined eligible for APTC, reselecting the same plan, with the updated information taking effect February 1. The FFE send the passive reenrollment effective January 1, then a January 31 term/February 1 initial CIC reflecting the update.	<ul style="list-style-type: none"> January 1 initial (no APTC): INSO4: 41 	Same	Yes/Yes	No	No
	<ul style="list-style-type: none"> February 1 CIC initial (with APTC): M834 	Same	No/No	No	No

Exhibit 13 illustrates multiple transactions for a single enrollment where the same enrollee visits

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HealthCare.gov on three separate occasions.

Exhibit 13: Multiple Transactions Illustrated for a Single Enrollment

Transaction Date	December 16	December 18	January 2
Description	Passive reenrollment sent	QI changes plan	QI reports a life change
Key 834 Codes	Origin Type on 834 = 11 (auto-reenroll) MRC = 41	Origin Type on 834 = 1 (FFE Online) MRC = EC Straight term/initial (not CIC)	Origin Type on 834 = 1 (FFE Online) MTC = 001 (Subscriber) Maintenance Enrollment Transaction
Electronic Data Interchange (EDI) Functional Code	I834AR	I834	M834

For detailed transaction requirements, issuers should continue to consult the Companion Guide instructions related to the ASC X12 Benefit Enrollment and Maintenance 834 Transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the FFEs. The Companion Guide can be accessed at <https://zone.cms.gov/document/asc-x12-005010-834-companion-guide>.

3.3.2 CSR & APTC Calculations on Passive Reenrollments

For enrollees who do not contact the Exchanges to obtain an updated eligibility determination and select QHPs by December 15, the Exchange will establish future plan year eligibility as follows:

- First, where an enrollee was in the special notice group, opt-out group, did not reconcile group, or repeat passive reenrollment group, the Exchange will discontinue APTC and income-based CSR.
- Second, where an enrollee with APTC or income-based CSR does not fall into the special notice group, opt-out group, did not reconcile group, or repeat passive reenrollment group, the Exchange will use the current year family size and the most recent household income and other eligibility information available, updated FPL tables, and updated benchmark plan premium information to calculate APTC and determine eligibility for income-based CSR for the next plan year.

Enrollees who actively return to the Exchanges to submit updated eligibility information for next year coverage will have their eligibility re-determined according to standard processes, with updated eligibility taking effect according to the effective dates described in 45 CFR §155.410(f).

3.4 Additional Files and Transactions to Support Issuers with Auto-Renewal

The FFEs communicate the vast majority of renewals (both active and passive) and new enrollment to issuers via 834 enrollment transactions. Because of the unique data architecture of the Exchange, additional files and transactions are also sent to issuers to inform the issuer of the FFEs enrollment. For example, the Switch File (3.4.1) tells the current year issuer to end coverage December 31, letting the issuer know that no auto-reenrollment should be expected, while the Passive Cancel File (3.4.2) eliminates duplicate coverage created in error. The Cancel Carry Forward (3.4.3) job cancels auto-renewals where eligibility for auto-renewal ended when the associated current year policy terminated after BAR.

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3.4.1 Enrollee Switch File

When an enrollee whose policy is in current (not cancelled or terminated) status completes an active reenrollment for next year coverage in a plan offered by a different issuer from the current year issuer, the FFEs do not send the current year issuer an 834 termination transaction. Rather, for enrollees for whom the FFEs have already sent passive reenrollments, the current year issuer will receive a cancellation for the next year passive enrollment, which is the signal to non-renew coverage unless another enrollment transaction is received. However, for enrollees who actively switch issuers for the new plan year and for whom no passive enrollment has been sent, there is no passive reenrollment to cancel.

To address this, the FFEs produces an electronic file for each issuer offering plans through the FFEs that identifies the issuer's current subscribers who have actively reenrolled in next year coverage offered by a different issuer. The file is generated daily beginning shortly after the start of OEP until around the cut-off for January coverage. Each Enrollee Switch File (sent EFT SWTFL) will be cumulative, identifying current enrollees who have switched issuers as of their most recent plan selection on the day before the file is generated. Only subscribers who have not been auto-reenrolled and actively switch issuers for the future plan year are candidates for the Switch File.

If an enrollee who has switched issuers for next year subsequently switches back to a plan offered by the enrollee's current year issuer, that enrollee will be removed from the next daily Switch File. A QDP subscriber will appear on the Switch File if the current subscriber either actively enrolled in a QHP while declining QDP coverage for the next plan year, or if the QDP subscriber actively switched to a different QDP issuer.

3.4.2 Passive Cancel Job

When enrollees or their assisters fail to access their existing pre-populated future year application and create a new application for future year coverage, a duplicate policy is created. The FFEs will cancel passive reenrollments that duplicate active enrollments for future year coverage via the Passive Cancel Job. This job is scheduled to run periodically in November and December. Issuers will receive these files in IPA layout via EFT BARCNX. These enrollments have already been cancelled by the FFEs and the issuer should similarly cancel the policy in its records. From January until the next OEP, de-duplication is performed by the Overlap Clean-up job visible on the Pre-Audit File.

For more information on these files including recommended issuer actions, please refer to the latest version of the *Standard Issuer Enrollment Data Files* document, available on CMS zONE at <https://zone.cms.gov/document/enrollment-data-reconciliation>.

Or on REGTAP at https://www.regtap.info/reg_librarye.php?i=2606.

3.4.3 Cancel Carry Forward Job

During OE, an enrollee or issuer may terminate (or even cancel) the current year coverage after the FFEs have sent the passive reenrollment for future year coverage, such as terminations for non-payment. The Cancel Carry Forward job cancels auto-reenrollments (policy origin of 11) that are linked to a prior year enrollment that has been cancelled or terminated after auto-renewal. Since the passive reenrollments were created based upon the prior year coverage that has subsequently ended, the Cancel Carry Forward job "carries forward" the termination (or cancel) to cancel the future year's enrollment.

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The FFEs will send I834 cancels with AMRC of CANCEL-CARRYFORWARD on a periodic basis from November through March to cancel future year auto-renewals associated with prior year policies that later terminated or cancelled after BAR. Issuers will review the cancellations documented in the file and ensure the cancellations are applied to the appropriate passive reenrollments in their system, taking care to cancel using the FFE Policy ID (not Subscriber ID). Issuers will also see these cancellations reflected in the Enrollment Pre-Audit (AUD) Files.

3.4.4 BAR Progress Report

In the run up to and throughout the OEP, the FFEs will send QHP and QDP issuers that are expecting renewals (i.e., continue to offer QHPs through the Exchange) a daily report that totals the auto-renewals sent to them as of midnight the night before the report's generation EFT BARPGx. The report compares the count of "BAR-eligible" policies (current year policies in good standing as of that incremental run of BAR, updated periodically throughout the OEP) with the actual BAR enrollments sent by the FFEs. Issuers can use the report to track progress and report problems. For example, the issuer may realize from a lower-than-expected BAR eligible count that the issuer has accidentally terminated enrollments and seek reinstatements.

3.4.5 Effectuation at Reenrollment and CIC

Issuers do not need to send the FFEs an effectuation transaction for any previously effectuated enrollment passively, or actively reenrolling in coverage (with the same issuer as identified by the five-digit HIOS ID), as long as the enrollment has the same FFE-assigned Subscriber ID for both plan years. Similarly, issuers need not send effectuations when an enrollee selects a plan in the same product in an enrollment update reported through a CIC.

However, effectuation confirmation transactions and binder payments are required for enrollments with a new subscriber, such as a young adult child being reenrolled as a new subscriber in a passive reenrollment age-off scenario. Issuers must also send effectuation confirmation transactions and collect binder payments for active enrollments for new enrollees and for returning enrollees who did not have continuous coverage with the issuer.

3.4.6 Life Changes During the OEP

An enrollee is able to report life changes triggering CIC transactions to issuers for both current year and next year coverage during the OEP. Changes to current year coverage, such as the addition of a baby or spouse, will be reflected on the passive reenrollment for next year coverage if reported to the FFEs by December 15. After December 15, changes to current year coverage cannot be initiated by the enrollee in self-service mode on HealthCare.gov but must instead be made through the Marketplace Call Center, which can also assist enrollees in updating their applications and coverage for both the current and next year, if necessary.

Enrollees who have actively selected next year coverage by December 15, and subsequently want to update their current year coverage based on a CIC should contact the Marketplace Call Center, which will also update their next year coverage as well.

3.4.7 Tobacco Rating at Time of Reenrollment

For passive reenrollments, the FFEs use the same tobacco status as the current year. In rare cases of technical error during passive enrollment, a policy may have an incorrect rating for tobacco status,

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issuers may restore the tobacco status inadvertently changed in a passive reenrollment through reconciliation (see Section 3.2.2).

During the OEP or an SEP, enrollees can actively update their enrollment to change their last date of tobacco use such that an enrollee would be eligible to go from tobacco-rated to non-tobacco rated and vice versa, with the change taking effect with a prospective effective date basis. Issuers should honor tobacco status changes made during an active update during an OEP or SEP.

3.4.8 Medicare Enrollment and Non-Renewals

Section 1882(d)(3)(A)(i)(I) of the Social Security Act (the Medicare anti-duplication provision) prohibits issuers, A/Bs, and web-brokers who know a QI is enrolled or entitled to Medicare from selling or issuing individual health insurance coverage that duplicates⁸ QI's Medicare or Medicaid benefits. The Medicare anti-duplication provision applies even if the beneficiary has only Part A or only Part B Medicare and is intended to protect Medicare beneficiaries from fraudulent or abusive practices leading to the purchase of excessive or unnecessary coverage. Employer sponsored coverage, such as plans sold in the Federally-Facilitated Small Business Health Options Program (FF-SHOP), are explicitly exempt from the Medicare anti-duplication provision.⁹

Sections 2703 and 2742 of the Public Health Service Act, and promulgated regulations at 45 CFR §§147.106 and 148.122, generally require guaranteed renewability of coverage for employers and individuals in the group and individual health insurance markets. Until 2017, the guaranteed renewability regulations did not offer Medicare eligibility or entitlement as a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market. However, the HHS Notice of Benefit and Payment Parameters for 2018 proposed and finalized a regulatory interpretation of the Medicare anti-duplication and guaranteed renewability provisions, which prohibits issuers that have knowledge that an enrollee in individual health insurance coverage is entitled to Medicare Part A or enrolled in Medicare Part B from renewing the individual health insurance coverage if it would duplicate Medicare or Medicaid benefits to which the enrollee is entitled, unless the renewal is effectuated under the same policy or contract of insurance. State insurance rules determine when a change in policy or contract of insurance has occurred.

Since January 17, 2017,¹⁰ QHP issuers that have knowledge that an enrollment covers a QHP enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B must non-renew the entire policy if the QHP reenrollment plan is a change of policy or contract into coverage that duplicates Medicare or Medicaid benefits to which the enrollee is entitled. The issuer should send a termination transaction to the FFEs ending coverage December 31 with an AMRC of TERM-ANTIDUPLICATION near the end of the plan year (CANCEL-ANTIDUPLICATION on the future year policy is also acceptable).

A QHP issuer should not presume that all individuals aged 65 or older are entitled to or enrolled in Medicare. QHP issuers must send a termination or cancellation notice, pursuant to 45 CFR §§155.430(b)(2)(i) and 156.270(b)(1), to any enrollees whose coverage has been non-renewed due to an enrollee in the enrollment group being a Medicare beneficiary. The termination notice should advise the non-Medicare enrollees on the non-renewed policy that they will be eligible for an SEP and to actively reenroll in another policy for continued coverage, making the Medicare enrollee a non-

⁸ See section 1882(d)(3)(A)(iv) of the Social Security Act (SSA) for the definition of "duplicate."

⁹ See section 1882(d)(3)(C) of the SSA.

¹⁰ January 17, 2017, is the effective date of the Final HHS Notice of Benefit and Payment Parameters for 2018.

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applicant. The Marketplace Call Center will have lists of enrollees eligible for the SEP and enrollees will not be required to submit documentation as the circumstances are already verified. Please refer to Section 6 for information on SEPs.

For enrollees that become eligible for benefits under Medicare after enrolling in coverage through Exchanges, the enrollee may maintain coverage until coverage is lawfully terminated in accordance with the Medicare anti-duplication provision, as described above, or otherwise.

However, the QI loses eligibility for APTC and CSR when the enrollee becomes eligible for MEC Medicare, as determined by IRS regulations. QHPs are encouraged to ask an enrollee who is newly eligible for benefits under Medicare whether the enrollee wishes to maintain coverage in a QHP and to provide instructions about how such an enrollee can report a change to the Marketplace to terminate coverage or stop receipt of APTC and CSR to reduce the burden when filing annual federal income taxes.

For additional operational guidance regarding termination or nonrenewal transactions for Medicare beneficiaries, please refer to the annually published OEP transaction summary guidance available on **Error! Hyperlink reference not valid.**www.regtap.info. Furthermore, for additional policy and technical guidance regarding the Medicare anti-duplication process, please refer to https://www.regtap.info/uploads/library/ENR_MedicareNonRenewalProcessOE2020_091619_5CR_091919.pdf.

4. ENROLLMENT IN THE FF-SHOP (APPLICABLE TO FF-SHOPS AND UNLESS OTHERWISE NOTED, SBE-FPs FOR SHOPS, QHPs/QDPs)¹¹

Small employers that meet the criteria set forth in 45 CFR §155.710, may participate in Federally-Facilitated Small Business Health Options Programs (FF-SHOPs) and State-Based Exchanges on the Federal Platform (SBE-FPs) for SHOPS (for convenience, referred to in this section collectively as FF-SHOPs) and purchase Qualified Health Plans/Qualified Dental Plans (QHPs/QDPs) through a SHOP-registered Agent or Broker (A/B) or through an issuer. Employers will no longer use HealthCare.gov to enroll in FF-SHOP coverage.

4.1 Eligibility and Enrollment

To have coverage considered to be purchased through an FF-SHOP, small employers must obtain a positive eligibility determination (there is no timeline for which employers must obtain an eligibility determination), as required by 45 CFR §157.206, to be eligible to participate in the FF-SHOP. Additionally, there is no policy that prohibits issuers from asking employers for a positive SHOP eligibility determination prior to enrollment into a QHP. An eligibility determination form can be filed by employers, with an FF-SHOP, electronically on HealthCare.gov. CMS, as the operator of the FF-SHOP eligibility platform, determines eligibility for FF-SHOP applicants.

Employers will work with a SHOP-registered A/B, or with an issuer offering SHOP QHPs and/or QDPs to select a coverage option to offer to its employees.

An FF-SHOP must permit a qualified employer to offer all plans within a single level of coverage (i.e., platinum, gold, silver, or bronze for QHPs; and all available QDPs) to its qualified employees (known as horizontal choice). Qualified employers may also offer a single QHP and QDP.

In addition, an FF-SHOP may permit a qualified employer to offer “vertical choice.” If vertical choice is available in a state and offered by an employer, qualified employees can choose from all plans across all available actuarial value levels of coverage from a single issuer, or all QDPs from a single issuer. HHS provides FF-SHOP states the opportunity to recommend, on an annual basis, whether the FF-SHOP will make vertical choice available to employers in their state.

SBE-FPs for SHOP have the same employer choice models available as FF-SHOPs. States with SBE-FPs for SHOP have an annual opportunity to opt out of making vertical choice available to employers in their states.

Thus, in states where vertical choice is available, a qualified employer has a choice of three employer choice options for both QHPs and QDPs: a single plan, all available plans at a single actuarial value level of coverage (or all QDPs) (horizontal choice), and a choice of all plans offered by a single issuer across all available levels of coverage (or all QDPs from a single issuer) (vertical choice). In states where vertical choice is not an available option for qualified employers, the single plan option and horizontal choice option are available to qualified employers.

¹¹ SHOP instructions as furnished here, are only applicable for SHOP plans that begin on or after 1/1/2018. For information related to plan years that began before 1/1/2018, issuers should refer to previous enrollment manuals.

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The following states have vertical choice available to qualified employers for plan year 2021: Alabama, Alaska, Arizona, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.¹²

In the absence of a central online FF-SHOP enrollment system and premium aggregation/billing services, employers (with or without the assistance of a SHOP-registered A/B) should contact the issuers of the QHPs in which they want to offer their employees coverage, for all the necessary application and enrollment information. Participating FF-SHOP issuers are required to accept and enroll all SHOP enrollments that are offered through employee choice as long as the group has met the applicable minimum participation rate for their state as outlined in 45 CFR §155.705.

4.1.1 Retirees

An employer may offer coverage to former employees, including retirees, through FF-SHOPs.

4.1.2 COBRA

An employer may provide COBRA continuation coverage through an FF-SHOP. Consistent with their legal obligations as plan sponsors under COBRA, employers should notify enrollees of their eligibility to enroll in COBRA continuation coverage.

4.2 Minimum Participation Rates in the FF-SHOP

SHOPs may authorize a uniform group participation rate for the offering of health insurance coverage in the SHOP, which must be a single, uniform rate that applies to all groups and issuers in the SHOP, based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP(s) or QDP of any particular issuer. If an employer fails to meet the requirement, it may revise its offer of coverage to encourage more employees to participate in the FF-SHOP. If the employer remains unable to meet the FF-SHOP minimum participation rate, the group's ability to complete an initial group enrollment or renewal through a FF-SHOP may be restricted to a limited enrollment period (November 15 – December 15) when the minimum participation rate may not be enforced by issuers, pursuant to 45 CFR §147.104(b)(1)(B). Mid-year fluctuations in a group's participation rate does not affect its ability to maintain coverage through an FF-SHOP.

The default minimum participation rate in an FF-SHOP is 70%. If a state has set a different minimum participation rate by law, or if there is evidence that a majority of QHP issuers in a state commonly use a different minimum participation rate, the FF-SHOP may have opted to use the state-specific rate rather than the 70% rate.

Employers and issuers should work together to determine whether a group satisfies the applicable minimum participation rate. If an employer offers employees a choice of plans, the group's participation rate will still be calculated at the group level. Issuers are required to accept enrollments from a group that has met the applicable minimum participation rate, even if only one member from a group chooses to enroll with a particular issuer.

¹² <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2020-Implementation-of-Vertical-Choice>

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4.3 Initial Enrollment

A qualified employer may complete an initial group enrollment into an FF-SHOP QHP or QDP at any point during the year, subject to applicable minimum participation requirements. During the initial group enrollment process, employers may establish a waiting period that applies to newly eligible employees. CMS notes that the effective date of coverage selected by a qualified employer remains subject to the limit on waiting periods under 45 CFR §147.116. Issuers may set enrollment timelines for FF-SHOP groups as permitted under 45 CFR §§147.104 and 155.726. Generally, except in states that have elected to merge their individual and small group risk pools under section 1312(c)(3) of the Patient Protection and Affordable Care Act (PPACA),¹³ a qualified employer's plan year lasts for 12 months from the initial coverage effective date.

4.4 Special Enrollment Periods

Pursuant to 45 CFR §155.726(c) and §155.420, special enrollment periods (SEPs) constitute periods outside of the initial group enrollment period or annual open enrollment period when an eligible employee and (if applicable) their dependents may enroll in a QHP/QDP or elect to change a current QHP/QDP (if employee choice is offered). Issuers are required to grant SEPs as described under 45 CFR §155.726(c), which cross-references most, but not all, of the qualifying events listed at 45 CFR §155.420(d). Specifically, SEPs described in 45 CFR §155.420(d)(1)(ii), (3), (6), (13), and (14) do not apply in SHOPS. Issuers are responsible for completing enrollments, providing the SEPs set forth in regulation and complying with the applicable coverage effective dates. **Please refer to Section 6 for more information on SEPs.**

Note that when Section 6 refers individuals to the Marketplace Call Center, FF-SHOP enrollees should call the FF-SHOP Hotline at 1-800-706-7893 (TTY: 1-888-201-6445).

4.5 FF-SHOP Appeals

Pursuant to 45 CFR §155.741(c), employers have the right to appeal a notice of denial of eligibility under §155.716(e). They may also appeal the failure of an FF-SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination.

Under 45 CFR §155.741(k)(3), if an employer is found eligible under the appeal decision, then at the employer's option, the effective date of coverage or enrollment through an FF-SHOP under the decision can either be made retroactive to the effective date of coverage or enrollment through an FF-SHOP that the employer would have had if the employer had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision. If the employer is found ineligible under the decision, then the appeal decision is effective as of the date of the notice of the appeal decision.

The SHOP Employer Appeal Request form can be found on HealthCare.gov at <https://www.healthcare.gov/small-businesses/choose-and-enroll/appeal-a-shop-decision/>.

FF-SHOPs are no longer involved in determining employee eligibility and processing their enrollment. As a result, FF-SHOPs do not accept appeal requests for employees. An employee may, however, file a complaint with the FF-SHOP if an issuer does not permit an employee to obtain SHOP coverage

¹³ For plan years beginning in 2018, no states with an FF-SHOP have merged markets.

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during a qualifying SEP. An employee may file a complaint by sending an encrypted email to shop@cms.hhs.gov documenting the concern and providing evidence to support the claim. At no time should employees or others send PII as part of an e-mail communication to CMS.

4.6 Plan Compare (See Plans and Prices)

Qualified employers can view QHPs and QDPs using the plan comparison tool on HealthCare.gov. Once an employer identifies a plan or plans that the employer would like to offer to employees, the employer will work with a SHOP-registered A/B or an issuer to begin enrollment into a SHOP QHP or QDP.

4.7 FF-SHOP Hotline Functionality

4.7.1 Qualified Employers

A single hotline is available for all FF-SHOPs and SBE-FP for SHOPs. Employers may use the FF-SHOP Hotline to obtain basic information about SHOPs. Employers with questions regarding enrollment will be directed to SHOP registered A/Bs or to participating SHOP issuers.

4.7.2 Cases of Suspected Fraud or Ineligibility

CMS works with DOIs, issuers, employers, employees, A/Bs, and other entities to identify and address potential ineligibility and suspected fraud occurring in connection with participation in the FF-SHOPs. To report an incident of potential ineligibility or suspected fraud in the FF-SHOPs, issuers should send an encrypted email to shop@cms.hhs.gov documenting the concern and providing evidence to support the claim. At no time should issuers and others send PII as part of an e-mail communication to CMS. Note that the rescission approval process described in Section 2.3 and at 45 CFR §155.430(b)(2)(iii) does not apply to SHOPs.

4.8 Cancellations and Terminations in the FF-SHOPs

The FF-SHOPs will no longer determine the timing, form, and manner in which coverage in an FF-SHOP QHP may be cancelled or terminated. Employers and employees may request cancellations or terminations of coverage through their SHOP-registered A/B or through the issuer. Issuers are responsible for conducting terminations of QHP coverage and sending termination notices in accordance with applicable Federal and State Law.

4.9 Renewals in the FF-SHOPS

Renewals into FF-SHOP plans should occur through a SHOP-registered A/B or with the issuer. Issuers should adhere to the rules associated with renewals in accordance with applicable State and Federal Law.

4.10 Dependent Age-Offs in the FF-SHOPs

Section 2714 of the Public Health Service Act, implemented at 45 CFR §147.120, states that a group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children must continue to make such coverage available for an adult child until the child turns 26 years of age. However, states may have varying rules on the maximum

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dependent age-off, provided it is at least age 26. Information on specific state rules must be obtained directly from the applicable state regulatory authority. Issuers should handle dependent age-offs in accordance with applicable State and Federal Law.

4.11 FF-SHOP Required Notices

The FF-SHOP issues notices related to an employer's eligibility to participate in an FF-SHOP, as required under 45 CFR §155.716. Issuers are required to send all other notices as required by applicable State and Federal Law.

5. DIRECT ENROLLMENT (APPLICABLE TO THE INDIVIDUAL MARKET FFEs, QHPs/QDPs)

Direct Enrollment (DE) is an enrollment process that allows new applicants and existing enrollees to enroll in a Qualified Health Plan (QHP)¹⁴ (either directly with a QHP issuer or through a Federally-Facilitated Exchange (FFE)-registered Agent or Broker [A/B]) in a manner considered to be through the FFEs during an Open Enrollment Period (OEP) or special enrollment period (SEP), when the process is originated through either a CMS-approved QHP issuer website or CMS-approved web-broker website (referred to as DE Entity websites). Enrollees also have the ability to report life changes through DE.

Currently, the FFEs offer two different options for QHP issuers and web-brokers (referred to as DE Entities) that wish to participate in DE. First, there is the classic DE pathway, which is also known as the “double-redirect” pathway. Second, there is the Enhanced DE (EDE) pathway. References to “DE” in this manual without specifying either classic DE or EDE, are inclusive of both the classic DE and EDE pathways.

The classic or “double-redirect” DE pathway utilizes Security Assertion Markup Language (SAML) to securely transfer a qualified individual (QI) from a DE Entity’s website to HealthCare.gov, where the QI completes the FFE’s eligibility application. Once the eligibility application has been completed, the QI is securely redirected back to the DE Entity’s website for plan selection and enrollment. DE Entities then use Extensible Markup Language (XML) Application Programming Interfaces (APIs) to obtain a QI’s eligibility results and submit the QI’s enrollment to the FFEs. The APIs include the Fetch Eligibility service, which allows a DE Entity to obtain a QI’s eligibility results, and the Submit Enrollment service, which allows a DE Entity to submit a QI’s enrollment to the FFEs.

Technical specifications for the SAML, Fetch Eligibility, and Submit Enrollment services are outlined in both the “FFE DE API for Web-Brokers/Issuers Technical Specifications” and the “Federal Data Services Hub (DSH) DE Business Service Definitions (BSDs),” both of which can be found on CMS zONE at <https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials>.

The EDE pathway, unlike the classic DE pathway, does not require a QI to be redirected to HealthCare.gov to complete the eligibility application. Instead, DE Entities that use the EDE pathway are able to provide a complete enrollment experience on their websites, including hosting the eligibility application. While DE Entities can host the eligibility application on their sites for EDE, eligibility determinations are still made by the FFEs. DE Entities participating in EDE utilize a suite of JavaScript Object Notation (JSON) APIs that the FFEs make available to obtain eligibility results from the FFEs, create and update QI eligibility applications, obtain QI notices, and submit verification documentation, among other things. The XML Submit Enrollment API used for classic DE is also used for EDE. Technical specifications for the EDE APIs can be found on CMS zONE at <https://zone.cms.gov/document/enhanced-direct-enrollment-edo-documents-and-materials>.

The plan shopping experience for both DE pathways, including the display of available plans,

¹⁴ As detailed in the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule (77 Fed. Reg. 18310, 18315) (March 27, 2012), with some limited exceptions, QDPs are considered a type of QHP. Unless indicated otherwise, references to QHPs in Section 5 include QDPs.

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selection of advance payments of the premium tax credit (APTC) amounts (for those who are eligible), and the submission of plan selections, is implemented by the DE Entity on its website and in accordance with applicable CMS requirements.

DE Entities that wish to access the above CMS zONE links, can do so by creating an account at portal.cms.gov (if one has not been created already). Once an account has been created, the user must request access to CMS zONE via their portal.cms.gov account.

Once access to CMS zONE is approved, the user can access the above links by logging into zone.cms.gov with their portal.cms.gov login.

QHP issuers and web-brokers that are interested in participating in DE should send any questions to DirectEnrollment@cms.hhs.gov.

5.1 Guidelines for Specific QI Scenarios

The FFEs provide eligibility results to DE Entities for those individuals seeking coverage through the DE Entity's website. The FFEs also provide information about whether each applicant using the DE Entity's website is eligible for enrollment in a QHP through the FFEs and, when the applicant has applied for financial assistance, the FFEs make a determination of eligibility for APTC and cost-sharing reduction (CSR) and perform an assessment or determination of eligibility for Medicaid and/or the Children's Health Insurance Program (CHIP), depending on the state's election.

5.1.1 Applicant Not Eligible for QHP Enrollment

If an applicant using DE is determined ineligible for enrollment in a QHP through the FFEs, this information will be provided to the applicant and DE Entity, and the DE Entity will review the determination with the applicant. The applicant can then view and select a plan offered outside the FFEs, if desired.

5.1.2 Applicant is Eligible for QHP Enrollment and APTC/CSR

If an applicant using DE is found eligible for enrollment in a QHP through the FFEs and is determined eligible for APTC or CSR, this information will be provided to the applicant and DE Entity, and the DE Entity will review the information with the applicant. DE Entities must provide applicants who are eligible for APTC the option to select the amount of APTC they want to apply towards the reduction of their share of the premiums during the plan selection process. For applicants eligible for income-based CSR, a DE Entity should only display the CSR plan variant that an individual is eligible for when displaying any silver QHP, or any metal-level QHP for enrollees eligible for CSR due to their status as either a member of a federally recognized Indian tribe or Alaska Native Claims Settlement Act (ANCSA) Corporation Shareholder.

5.1.3 Applicant is Eligible for QHP Enrollment but Not for APTC/CSR

If an applicant using DE is found eligible for enrollment in a QHP through the FFEs but is determined ineligible for APTC or CSR, this information will be provided to the applicant and DE Entity, and the DE Entity will review the information with the applicant. During subsequent plan selection, the DE Entity should not include any APTC amount for an applicant who is not eligible for APTC or display CSR plan variations for an applicant who is not eligible for CSR.

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5.1.4 Applicant is Eligible for Medicaid or CHIP

If an applicant using DE is assessed as potentially eligible or determined eligible for Medicaid or CHIP, the FFEs send the applicant's information to the appropriate state Medicaid or CHIP agency. The state agency will subsequently follow up with the applicant, or the applicant may contact the relevant state agency regarding their status. The applicant and DE Entity will also be informed of the applicant's Medicaid or CHIP eligibility, and the DE Entity will review the information with the applicant.

Medicaid/CHIP Modified Adjusted Gross Income (MAGI) Eligibility Scenario: If an applicant using DE is determined eligible or assessed as potentially eligible for Medicaid or CHIP based on MAGI, their account is transferred to the state Medicaid/CHIP agency. The applicant and DE Entity will be informed of the applicant's Medicaid or CHIP eligibility, and the DE Entity will review the information with the applicant. Applicants eligible for MAGI-based Medicaid or CHIP will not be eligible for a QHP on a financial assistance application but can create a non-financial assistance application, to determine eligibility for a QHP without financial assistance. The DE Entity should not include those eligible for Medicaid or CHIP who are not also eligible for a QHP in an enrollment group on a financial assistance application because the DE Entity will receive an error during the enrollment submission since the system can only accept a submitted enrollment for applicants who are marked as eligible for a QHP.

If an applicant assessed as potentially eligible for Medicaid or CHIP is determined ineligible for Medicaid or CHIP by the state agency, the state agency transfers the applicant's account back to the FFE, and the applicant is sent a notice from the FFE about their eligibility for QHP coverage through the FFE and for APTC and CSR. If the applicant receives an updated determination of eligibility to enroll in a QHP through the FFE, and enrolls through the DE Entity's website, the updated eligibility determination will be provided to the DE Entity and the applicant will be allowed to select a QHP via the DE Entity's website.

Medicaid/CHIP Non-MAGI Eligibility Scenario: The FFEs will also screen for eligibility for Medicaid based on factors other than MAGI (i.e., disability, long-term care needed, applicants age 65 and older) and allow applicants to request an eligibility determination on one or more of these bases. If an applicant indicates on the application that they are age 65 or older, or that they are disabled or have a long-term care need, but they also have been determined eligible for enrollment in a QHP through the FFE, the applicant and DE Entity will be informed that the applicant is eligible to select a QHP through the FFE (if the applicant wants to select a QHP pending the outcome of the non-MAGI Medicaid eligibility determination). If the applicant is eligible for APTC or CSR, pending the outcome of the non-MAGI determination, the amount of APTC or CSR available will be provided to the applicant and DE Entity and should be used during the subsequent plan selection process.

5.1.5 Households that Include QIs Eligible for Different Coverage Programs

For households that include individuals eligible for different coverage programs (e.g., QHP with APTC, Medicaid), DE Entities should follow the guidelines outlined above for each applicant in the household. When an applicant is determined eligible or assessed as potentially eligible for Medicaid or CHIP based on MAGI or non-MAGI (e.g., disability, long-term care needed, applicants age 65 and older) circumstances, the FFEs will transfer application information to the state Medicaid or CHIP agency, as applicable. DE Entities should not include any applicants in the QHP selection process who

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are not listed as eligible for enrollment in a QHP through the Exchange, since the DE Entity would receive an error during the enrollment submission due to the fact that the system can only accept an enrollment request for applicants that are marked as eligible for a QHP.

DE Entities have the ability to create their own shopping experience on their websites, subject to applicable CMS requirements. Nevertheless, if a household has applicants who are determined eligible for QHP enrollment through the FFEs and others who are not eligible, the DE Entity website must first complete the plan selection process for applicants eligible for QHP enrollment through the FFEs prior to completing the plan selection process for individuals who are not eligible for QHP enrollment through the FFEs. While the DE Entity may not enroll applicants in Exchange coverage who are determined ineligible for QHPs, the DE Entity may enroll them in coverage outside the Exchange after completing the enrollment process for those applicants who are QHP-eligible.

5.2 Enrollment Groups

Due to system limitations, DE for applicants applying for financial assistance through the FFEs is currently limited to enrollment groups consisting of a single tax household (that is, when applying for financial assistance, only applicants who are included on the same tax return are able to enroll together in a QHP through the FFEs using the DE process). However, DE does accommodate enrollment in QHPs through the FFEs for enrollment groups that include multiple-tax households as long as all of the applicants are not seeking financial assistance.

If a group of applicants apply for financial assistance through the FFEs using DE, and the applicants are identified as having multiple-tax households, the FFEs will relay this information to the applicant and DE Entity, and the DE Entity will review the information with the applicant. The DE Entity should advise the applicants that DE does not support enrollment of multi-tax households when financial assistance is sought. The DE Entity should also advise the applicants that if they want to continue using DE, they must complete separate applications for financial assistance (a separate application for each tax household), or they can complete a non-financial assistance application if they would like to enroll together using DE.

DE Entities must also use an issuer's current subscriber-dependent rules when determining who can be insured under one policy. DE Entity websites that are capable of supporting multiple enrollment groups should give QIs the ability to regroup into different enrollment groups, either combining into fewer enrollment groups (if issuer relationship rules permit), or separating into different valid enrollment groups, if desired. The "FFE DE API for Web-Brokers/Issuers Technical Specifications"¹⁵ addresses how to allocate APTC when there are multiple enrollment groups. If a DE Entity offering a classic DE pathway is unable to support multiple enrollment groups, it must make the applicant aware that they can access this functionality at HealthCare.gov, as described in the disclaimers below. Note that EDE Entity websites must include functionality that allows QIs to group in any way that is acceptable based on the issuer's current business rules, and EDE Entities are therefore not permitted to display the applicable portion of the disclaimer (see Section 5.3.1) required under 45 CFR §156.1230(a)(1)(iv) in lieu of supporting multiple enrollment group functionality.

It is important to note that all QIs on a single application may only enroll using DE if doing so at the same time with a single DE Entity. A QI cannot go to DE Entity A's website and enroll some of the tax household and then go to DE Entity B's website to enroll the remaining QIs. The enrollment

¹⁵ See <https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials> (requires zONE access).

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request must include all policies for the application, and the DE Entity should not send multiple individual enrollment requests for members of a tax household as this will cause an error.

Additionally, due to operational limitations, dental-only enrollment is not permitted via DE. Qualified Dental Plan (QDP) issuers who only offer dental coverage therefore are not permitted to participate in DE at this time. However, concurrent enrollment in both a QHP and a QDP is permitted via DE. Applicants who wish to enroll in a QDP via DE may do so after making a QHP selection. DE Entities that offer concurrent QHP and QDP enrollment must note, however, that any elected APTC must first be applied towards the essential health benefits (EHB) portion of the QHP, and then any remaining APTC can only be applied towards any pediatric (i.e., for those applicants under the age of 19) portion of the dental premium.

APTC cannot be applied towards any dental premium applicable to an adult enrollee. The “FFE DE API for Web-Brokers/Issuers Technical Specifications” addresses in greater detail how to allocate APTC. QHP issuer DE Entities that do not offer dental coverage must also provide a disclaimer to applicants, stating that dental coverage is available via HealthCare.gov.

5.3 QHP Display Guidance

QHP issuers and web-brokers that are seeking approval or that have obtained approval to use DE must adhere to the applicable CMS requirements with respect to the display of QHP information. Different regulatory requirements extend to the DE Entity websites depending on whether they are QHP issuer websites or web-broker websites. Details on each follow.

5.3.1 QHP Issuer DE Entities

The QHP issuer DE Entity website:

1. Must, in accordance with 45 CFR §§156.1230(a)(1)(ii) and 155.205(b)(1)(i)-(viii), provide applicants the ability to view QHPs offered by the issuer and provide standardized comparative information on each available QHP, to the extent such information is required to be available, and that at a minimum includes:
 - a. Premium and cost-sharing information (total and net premium based on APTC and/or CSR);
 - b. Summary of benefits and coverage;
 - c. Identification of whether the QHP is a bronze, silver, gold, or platinum level plan, or a catastrophic plan;
 - d. The results of the enrollee satisfaction survey;
 - e. Quality ratings;
 - f. Medical loss ratio (MLR) information as reported to HHS;
 - g. Transparency of coverage measures reported to the Exchange during certification; and
 - h. The provider directory made available to the Exchange
2. Must, in accordance, with 45 CFR §155.221(b)(1), display and market QHPs and non-QHPs on separate website pages on its website. This includes not offering non-QHP health plans (e.g., short-term, limited-duration insurance) or non-QHP ancillary products (e.g., vision or accident insurance) alongside QHPs. QHP issuer DE Entities must also provide applicants the ability to search for off-Exchange products in a separate section of the website other than the QHP webpages; such products may be marketed and displayed after the QHP selection process has been completed.

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3. Should provide filters for searching through plan options on QHP issuer DE Entities' QHP websites, which may include, but are not limited to:
 - a. All plans
 - b. Premiums
 - c. Deductibles
 - d. Maximum out-of-pocket cost
 - e. Plan type (e.g., HMO, PPO)
 - f. Dental coverage included
 - g. Health Savings Account eligible
4. Must allow applicants to select and attest to their APTC amount, if applicable, up to the maximum for which they are eligible, as set forth in 45 CFR §156.1230(a)(1)(v), and subsequently update the net premium for the displayed QHPs. If an applicant is eligible for CSR, QHP issuer DE Entities should only display the CSR plan variant that an individual is found eligible for when displaying any silver QHP, or American Indian/Alaskan Native CSR variations, at any metal level, as appropriate.
5. Should ensure that information on its QHP webpages is provided to applicants in plain language and in a manner that is timely and provides effective communication for individuals living with disabilities and provides meaningful access for individuals with limited English proficiency at no cost to applicants.
6. Must, in accordance with 45 CFR §155.221(b)(3), limit marketing of non-QHPs during the Exchange eligibility application (if applicable) and QHP plan selection process in a manner that minimizes the likelihood that consumers will be confused as to what products are available through the Exchange and what products are not. For example, the QHP issuer DE Entity website must clearly distinguish between QHPs for which the QI is eligible and other non-QHPs that the QHP issuer may offer, and indicate that APTC and CSR apply only to QHPs offered through the FFEs, as set forth in 45 CFR §156.1230(a)(1)(iii).

QHP issuer DE Entities must ensure that the premiums charged to an applicant using DE are the same as the amount the FFEs would have calculated had the applicant selected a QHP via HealthCare.gov. It is important to note that the QHP issuer DE Entity is responsible for collecting information on the tobacco status of each applicant and should factor that in when calculating each enrollee's premium. Currently, the FFEs are only able to support changes in enrollees' tobacco status during open enrollment or an SEP as part of the enrollment XML file provided from issuers to the FFEs. QHP issuer DE Entities should refer to the other sections of this manual and the "FFE DE API for Web-Brokers/Issuers Technical Specifications"¹⁶ to ensure that they are correctly rating and applying the correct financial amounts for an enrollee based on their situation (e.g., new vs. existing enrollee making a mid-year change, effective date first of the month vs. mid-month, etc.).

QHP issuer DE Entities must provide an HHS-provided universal disclaimer that informs all applicants of the availability of other QHP products offered through the FFEs as set forth in 45 CFR §156.1230(a)(1)(iv). QHP issuer DE Entities must make this disclaimer available to all applicants regardless of how applicants communicate with the QHP issuer (e.g., through a website, by phone, in-person). The FFEs expect that QHP issuer DE Entities will make the disclaimer available at the beginning of the plan comparison process, and if an applicant is using a QHP issuer's website, the

¹⁶ See *supra* note 15.

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QHP issuer must prominently display this disclaimer when displaying plans to the applicant. The disclaimer must read:¹⁷

“Attention: This website is operated by [Name of Company] and is not the Health Insurance Marketplace® website at HealthCare.gov. This website **does not** display all Qualified Health Plans (QHPs) available through HealthCare.gov. To see all available QHP options, go to the Health Insurance Marketplace® website at HealthCare.gov.

Also, you should visit the Health Insurance Marketplace® website at HealthCare.gov if:

1. You want to select a catastrophic health plan. (**This only needs to be included if catastrophic plans are not offered by the QHP issuer.**)
2. You want to enroll members of your household in separate QHPs. (**This only needs to be included if the QHP issuer does not allow multiple enrollment groups for its classic DE pathway; note that EDE Entities are required to support multiple enrollment groups.**)
3. You want to enroll members of your household in dental coverage. [The plans offered here do not offer pediatric dental coverage and you want to choose a QHP offered by a different issuer that covers pediatric dental services or a separate dental plan with pediatric coverage.] (**This only needs to be included if the QHP issuer does not offer adult dental coverage or pediatric dental coverage.**)”

The following guidelines apply to the prominent display of the disclaimer:

- The disclaimer must be prominently displayed on both the initial QI landing page and on the landing page displaying QHP options that appear before the applicant makes a decision to purchase coverage (QHP selection page).
- The disclaimer must use the exact language provided by HHS.
- The disclaimer must include a functioning web link to the Health Insurance Marketplace® website (HealthCare.gov).
- The disclaimer must be viewable without requiring the user to select or “click on” an additional link.
- The disclaimer must be written in a font size no smaller than the majority of the text on the webpage.
- The disclaimer must be displayed in the same non-English language as any language(s) the QHP issuer maintains screens for on its website.
- The disclaimer must be noticeable in the context of the website (e.g., use a font color that contrasts with the background of the webpage).

5.3.2 Web-Broker DE Entities

Web-broker DE Entity websites must—in accordance with 45 CFR §155.220(c)(3)(i)(A) — disclose and display all QHP information provided by the Exchange or directly by QHP issuers, consistent with the requirements of 45 CFR §§155.205(b)(1) and 155.205(c), for all QHPs, including QDPs,¹⁸ offered

¹⁷ The portion of the disclaimer related to pediatric dental coverage, indicated in brackets, is not required but CMS encourages a QHP issuer that does not offer pediatric dental coverage to display this piece of the disclaimer.

¹⁸ See *supra* note 15. CMS expects all web-brokers to follow the same requirements for QDPs as for QHPs, including displaying on their websites all applicable QDPs offered through the Exchange and all available information specific to each

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through the Exchange.

If not directly provided by CMS, a web-broker may obtain additional information on health plan products (QHPs and QDPs) that are displayed on its website directly from those QHP and QDP issuers with whom it has a contractual relationship. The standardized comparative information on each available QHP that must be displayed includes the following minimum information:

1. Premium and cost-sharing information (total and net premium based on APTC and CSR);
2. Summary of benefits and coverage;
3. Identification of whether the QHP is a bronze, silver, gold, or platinum level plan, or a catastrophic plan;
4. The results of the enrollee satisfaction survey;
5. Quality ratings;
6. MLR information as reported to HHS;
7. Transparency of coverage measures reported to the Exchange during certification; and
8. The provider directory made available to the Exchange.

In accordance with 45 CFR §155.220(c)(3)(i)(A), if a web-broker's website for a QHP does not display all of the information required under 45 CFR §155.205(b)(1), it must prominently display the following standardized Plan Detail Disclaimer for the specific QHP:

“[Name of Company] isn't able to display all required plan information about this Qualified Health Plan at this time. To get more information about this Qualified Health Plan, visit the Health Insurance Marketplace® website at HealthCare.gov.”

The mandatory standardized Plan Detail Disclaimer must:

- Be prominently displayed where plan information on the QHP would normally appear, so it is noticeable to the QI;
- Be provided separately for each QHP where plan information is not displayed;
- State that the comparative information for all QHPs offered through the Exchange is available on HealthCare.gov;
- Use the exact language provided by HHS; and
- Include an operational link to the Health Insurance Marketplace® website (HealthCare.gov).

The web-broker DE Entity website:

1. Must, in accordance with 45 CFR §155.220(c)(3)(i)(A), adhere to the website display standards specified in 45 CFR §155.205(b)(1) and (c). Web-brokers must disclose and display all QHP information provided by the FFEs or directly by QHP or QDP issuers. CMS intends to issue separate future guidance related to display of quality ratings information consistent with FAQs released November 5, 2019.¹⁹
2. Must, in accordance with 45 CFR §155.220(c)(3)(i)(B), provide QIs the ability to view all QHPs offered through the Exchange. Web-brokers must display all QHPs available through an Exchange, irrespective of compensation or appointment arrangements.

QDP, as well as including the Plan Detail Disclaimer to the extent that all required QDP comparative information is not displayed on their websites.

¹⁹ Available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/QRS-FAQs-for-DE-Entities.pdf>.

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3. Must, in accordance with 45 CFR §155.220(c)(3)(i)(C) provide no financial incentives, such as rebates or giveaways.
4. Must, in accordance with 45 CFR §155.220(c)(3)(i)(D), display all QHP data provided by the Exchange. CMS makes detailed QHP data available to web-brokers registered with the FFEs through the release of the “QHP Landscape File”²⁰ and the “Health Insurance Exchange Public Use Files (PUF).”²¹ CMS recommends that web-brokers registered with the FFEs use these files, in addition to information a web-broker registered with the FFEs obtain through its relationships with QHP issuers, to display required QHP standardized comparative information. Alternatively, web-brokers can obtain a real-time feed of QHP information using the Marketplace API. If web-brokers are interested in integrating with the Marketplace API, the API key request form and related documentation can be found at <https://developer.cms.gov/marketplace-api/>.
5. Must, in accordance with 45 CFR §155.220(c)(3)(i)(F), provide QIs with the ability to withdraw at any time from the process and instead use the Exchange website.
6. Must, in accordance with 45 CFR §§155.220(c)(3)(i)(I) and (c)(3)(i)(J) prominently display information provided by the Exchange pertaining to a consumer’s eligibility for APTC or CSR and allow the consumer to select an amount for APTC, if applicable, and make related attestations.
7. Must, in accordance with 45 CFR §155.220(c)(3)(i)(L), not display QHP recommendations based on compensation the agent, broker, or web-broker receives from QHP issuers.
8. Must, in accordance with 45 CFR §155.221(b)(1), display and market QHPs and non-QHPs on separate website pages on its website. This includes not offering non-QHP health plans (e.g., short-term, limited-duration insurance) or non-QHP ancillary products (e.g., vision or accident insurance) alongside QHPs. Web-broker DE Entities must also provide applicants the ability to search for off-Exchange products in a separate section of the website other than the QHP webpages; such products may be marketed and displayed after the QHP selection process has been completed.
9. Must, in accordance with 45 CFR §155.221(b)(3), limit marketing of non-QHPs during the Exchange eligibility application and QHP plan selection process in a manner that minimizes the likelihood that consumers will be confused as to what products are available through the Exchange and what products are not. For example, the web-broker DE Entity website must clearly distinguish between QHPs for which the QI is eligible and other non-QHPs that the web-broker may offer and indicate that APTC and CSR apply only to QHPs offered through the FFEs.

Web-broker DE Entity websites must also prominently display the General non-FFEs Disclaimer in accordance with 45 CFR §155.220(c)(3)(i)(G). Please note this disclaimer was revised by CMS in October 2016²² to also address situations where web-brokers offer consumers assistance with other coverage options (e.g., off-Marketplace plans). The disclaimer must read:²³

“Attention: This website is operated by [Name of Company] and is not the Health Insurance

²⁰ Available at <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

²¹ Available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html>.

²² See <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Guidance-Web-brokers-FFMs.pdf>.

²³ The portion of the disclaimer related to pediatric dental coverage, indicated in brackets, is not required but CMS encourages a web-broker that does not offer pediatric dental coverage to display this piece of the disclaimer.

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Marketplace® website. In offering this website, [Name of Company] is required to comply with all applicable federal law, including the standards established under 45 CFR §§155.220(c) and (d) and standards established under 45 CFR §155.260 to protect the privacy and security of personally identifiable information. This website may not display all data on Qualified Health Plans (QHPs) being offered in your state through the Health Insurance Marketplace® website. To see all available data on QHP options in your state, go to the Health Insurance Marketplace® website at HealthCare.gov.

Also, you should visit the Health Insurance Marketplace® website at HealthCare.gov if:

- You want to select a catastrophic health plan. **(This only needs to be included if catastrophic plans are not offered by the web-broker.)**
- You want to enroll members of your household in separate QHPs. **(This only needs to be included if the web-broker does not allow multiple enrollment groups for its classic DE pathway; note that EDE Entities are required to support multiple enrollment groups.)**
- You want to enroll members of your household in dental coverage. [The plans offered here do not offer pediatric dental coverage and you want to choose a QHP offered by a different issuer that covers pediatric dental services or a separate dental plan with pediatric coverage.] **(This only needs to be included if the web-broker does not offer assistance with enrollment in adult dental coverage or pediatric dental coverage.)**

[Name of web-broker's website] offers the opportunity to enroll in either QHPs or off-Marketplace coverage. Please visit HealthCare.gov for information on the benefits of enrolling in a QHP. Off-Marketplace coverage is not eligible for the cost savings offered for coverage through the Marketplaces.” **(This final paragraph must be displayed if the web-broker offers consumers assistance with off-Marketplace coverage options.)**

The web-broker DE Entity must observe the following requirements for displaying the General non-FFE's Disclaimer:

- The Disclaimer must be prominently displayed on both the initial QI landing page and on the landing page displaying QHP options that appear before the applicant makes a decision to purchase coverage (QHP selection page).
- The Disclaimer must use the exact language provided by HHS.
- The Disclaimer must include a functioning web link to the Health Insurance Marketplace® website (HealthCare.gov).

CMS requires all disclaimers, including the web-broker General non-FFE's and Plan Detail Disclaimers, to be “prominently displayed.” CMS considers the disclaimers to be “prominently displayed” consistent with the description included in Section 5.3.1.

Web-brokers may change the font color, size, or graphic context of the disclaimer to ensure that it is noticeable to the applicant in the context of the website. However, the exact language of the General non-FFE's and Plan Detail Disclaimers must be used.

CMS expects that web-broker DE Entities prominently display language explaining to QIs that the web-broker has entered into an Agreement(s) with the FFEs and has agreed to conform to the website display and security standards in 45 CFR §§155.220(c)(3) and 155.260. In addition, consistent with 45 CFR §155.220(j)(2)(i), web-brokers and other A/Bs may not use “Marketplace” or “Exchange” or

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other words in the name of their businesses or websites if doing so could mislead a QI into believing they are visiting HealthCare.gov. Consistent with the obligation to provide QIs with correct information under 45 CFR §155.220(j)(2)(i), web-brokers registered with the FFEs should also advise QIs that APTC and CSR apply only to QHPs offered through the FFEs.

CMS expects web-brokers to display information for QHPs offered through the FFEs in a way that will not steer a QI to a particular QHP based upon financial considerations alone. Web-brokers may offer additional tools or decision support that the QI can use to navigate or refine the display of QHPs. CMS also expects that the web-broker will display language explaining to the QI the specific source and nature of web-broker compensation and that compensation does not affect the display of QHP options or premiums charged. Web-brokers must offer a QHP plan selection experience that is free from advertisements or information for other health insurance-related products and sponsored links advertising health insurance-related products (e.g., an advertisement for a QHP issuer). Once a QI has completed the QHP plan selection and enrollment, the web-broker may offer the QI the ability to search for additional products or services if desired. Such offers must be made in a section of the web-broker's website that is separate from the QHP display and plan selection.

CMS expects that web-broker DE Entities will clearly distinguish between QHPs for which the QI is eligible and QHPs for which the QI may not be eligible. For example, the display of child-only plans should be limited to QIs eligible for such coverage (e.g., individuals under the age of 21) to avoid confusion.

If a web-broker DE Entity offers the QI the use of additional sort functionality to alter the order of the QHPs listed, regardless of how the QI chooses to sort the QHPs (e.g., lowest monthly payment, lowest deductible), the web-broker website must still provide QIs the ability to view all QHPs offered through the FFEs in compliance with 45 CFR §155.220(c)(3)(i)(B).

A web-broker may also allow the QI to apply filters to the QHPs listed (e.g., metal level, provider network, issuer). In this case, web-brokers should ensure that if the QI were to select all of the available options for a certain filter (e.g., all available metal levels), the total number of plans displayed would remain consistent with the number of QHPs offered through the FFEs that satisfy the selection criteria. In addition, if a QI selects a certain filter (e.g., bronze metal level), the web-broker website should display all QHPs offered through the FFEs that satisfy that filter's description.

CMS generally expects that QIs are not charged a separate transaction or service fee for shopping or enrolling in a QHP through a web-broker's website. CMS recognizes that web-brokers may have invested significant resources to develop special software to assist QIs with selection and enrollment in QHPs offered through the FFEs, and some independent A/Bs may leverage those websites to facilitate QHP selection and enrollment. CMS believes that in these limited circumstances, where there is a bona fide service of value that goes beyond the traditional assistance provided by an A/B registered with the FFEs, it may be appropriate to allow for the collection of an additional fee. However, any practice of collecting such fees from QIs for providing assistance with QHP selection and enrollment through the FFEs would be subject to applicable state law. If permitted under state law, A/Bs and web-brokers that elect to pass on these types of costs to QIs for selecting and submitting QHP applications offered through the FFEs through a non-FFE website should provide a disclaimer to QIs that: 1) clearly discloses the amount and reason for the fee, and 2) informs the QI that he or she can apply through the FFE website (HealthCare.gov) at no cost.

A web-broker DE Entity can allow other A/Bs to use its website to enroll QIs, employers, and

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employees in a QHP through the FFEs by entering into a contractual or other arrangement.²⁴ The A/B accessing the web-broker website pursuant to the arrangement should be listed as the agent of record on the enrollment. The web-broker must verify that any other A/B accessing its website is licensed by the applicable state(s) and completed FFE registration for the current plan year (including completion of applicable training and execution of applicable Agreements with the FFEs).²⁵

A web-broker DE Entity that allows another A/B registered with the FFEs to use the web-broker's website must, as mandated by 45 CFR §155.220(c)(4)(i)(C), ensure that the web-broker's name and National Producer Number (NPN) to be prominently displayed:

- On every page of the website, even if the A/B registered with the FFEs accessing the web-broker's website is able to customize the appearance of the website; and
- On the cover or first page of all written materials containing QHP information that can be printed directly from the website. This includes all files containing QHP information that can be downloaded directly from or viewed directly on the website. Documents linked to or from the site that a separate entity maintains are not included in this definition.

CMS considers the information to be “prominently displayed” if it is consistent with the description in Section 5.3.1.

A web-broker may change the font color, size, or graphic context of the information to ensure that it is noticeable to the QI in the context of its website or the other written material. However, web-brokers must ensure the information is displayed as required by 45 CFR §155.220(c)(4)(i)(C) and related guidance.

The web-broker must terminate an A/B's access to its website if CMS determines that the A/B is in violation of any applicable FFE requirements.²⁶ In addition, web-brokers must report to HHS and applicable state regulators any potential material breach of the A/B FFE requirements, including the privacy and security standards under 45 CFR §155.260(b) by the A/B accessing its website, should the web-broker become aware of any such potential breach.²⁷

5.4 Mandatory Display Language for Consumers That Attest to a Health Reimbursement Arrangement Offer

DE Entities assisting QIs with enrollment must be aware that some QIs may need to attest to a Health Reimbursement Arrangement (HRA) offer when completing the eligibility application. The Fetch Eligibility API and Standalone Eligibility Services (SES) API responses will indicate when a QI attests to an HRA offer and will indicate if the FFE has determined affordability for the offer. The HRA offer, and whether or not the offer is accepted, and the HRA's affordability may impact an applicant's eligibility for a QHP or a QI's eligibility for APTC. Accordingly, DE Entities are required to display specific language to QIs with an HRA offer, depending on the type and affordability of the HRA offered to the QI. The “FFEs DE API for Web-Brokers/Issuers Technical Specifications” available on CMS zONE at <https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials> outlines the required language that DE Entities must display for various scenarios.

²⁴ 45 CFR §155.220(c)(4).

²⁵ 45 CFR §155.220(c)(4)(i)(B).

²⁶ 45 CFR §155.220(c)(4)(i)(D).

²⁷ 45 CFR §155.220(c)(4)(i)(E).

5.5 Mandatory Attestations

DE Entities using their own websites, and any A/Bs using a DE Entity website, to enroll individuals into QHPs in a manner considered to be through the FFEs are required to collect attestations for those households receiving APTC as set forth in 45 CFR §156.1230(a)(1)(v) (applicable to QHP issuers) and 45 CFR §155.220(c)(3)(i)(J) (applicable to web-brokers and A/B users of a web-broker's website). The FFEs will identify the expected tax filers for the coverage year from each tax household and the DE Entity, or the A/B using the DE Entity's website, must collect and retain an attestation from each tax filer. For each household identified as needing an attestation, the following language should be used:

- Advance payments of the premium tax credit (APTC) attestation
- Review the statements below for [tax filer(s) – household 1] (in a DE Consumer flow, this attestation should be displayed to the consumer in the DE Entity's User Interface (UI), whereas in an A/B flow, the A/B should verbally review the attestation with the consumer)
- I understand that because advance payments of the premium tax credit (APTC) will be paid on my behalf to reduce the cost of health insurance coverage for myself and/or my dependents:
- I must file a federal income tax return in [coverage year +1] for the tax year[coverage year].
- If I'm married at the end of [coverage year], I must file a joint income tax return with my spouse, unless an exception applies.
- I also expect that no one else will be able to claim me as a dependent on their [coverage year] federal income tax return.
- I'll claim a personal exemption deduction on my [coverage year] federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through this Marketplace and whose premium for coverage is paid in whole or in part by advance payments of the premium tax credit for which I am the applicable tax filer.
- If any of the above changes, I understand that it may impact my ability to get the premium tax credit.
- I also understand that when I file my [coverage year] federal income tax return, the Internal Revenue Service (IRS) will compare eligibility information for [coverage year] to what I reported on my Marketplace application, including the household income on my tax return with the household income on my application. I understand changes in eligibility information could affect eligibility for the premium tax credit. For example, if the household income on my tax return is lower than the amount of expected household income on my application, I may be eligible to get an additional premium tax credit amount. On the other hand, if the income on my tax return is higher than the amount of income on my application, I may owe additional federal income tax.

[Click "Agree" or "Disagree"]

Tax filer's signature(s)

[Name of Tax Filer(s)]

Upon sending the enrollment transaction to the FFEs, DE Entities indicate the amount of APTC the household has selected and confirm that the tax filer has attested to the language above.

Additionally, the DE Entity, or the A/B using the DE Entity's website, must maintain attestations for a

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minimum of 10 years.²⁸

²⁸ 45 CFR §§155.220(c)(3)(i)(E) and §156.705(c).

6. SPECIAL ENROLLMENT PERIODS (APPLICABLE TO INDIVIDUAL MARKET FFEs, QHPs/QDPs)

Pursuant to 45 CFR §155.410(a)(2), and 45 CFR §155.20, special enrollment periods (SEPs) allow a qualified individual (QI) or enrollee who experiences certain qualifying events to enroll in, or change enrollment in, a QHP through the Exchange outside of the annual Open Enrollment Periods (OEPs).

Exchanges must adhere to the parameters for SEPs defined at 45 CFR §155.420.

Section 6 provides an overview of events that trigger SEPs and details about how the Federally-Facilitated Exchanges (FFEs) administer them. It includes material that applies to the FFEs and to the Federally-Facilitated Small Business Health Options Program (FF-SHOP); information on SEPs that apply only to the FF-SHOP is available in Section 4.4. Information on the applicability of binder payments rules is available in Section 7.1.

6.1 SEP Pre-Enrollment Verification

Pursuant to the preamble of the 2017 Market Stabilization Rule,²⁹ the FFEs conduct pre-enrollment verification of newly enrolling individuals' SEP eligibility. This SEP verification, which applies to the most common SEP types, is intended to promote program integrity and continuous coverage, protect the risk pool, and stabilize rates. See Exhibit 14 for details on which SEP types are subject to SEP verification. The preamble of the 2017 Market Stabilization Rule provided State-Based Exchanges (SBEs) with flexibility to determine whether and how to implement SEP pre-enrollment verification.

SEP verification does not impact the individual's Exchange-generated effective date, which is typically determined by the SEP triggering event and the date the individual selects a QHP (see Section 6.5 for more information on SEP triggering events and coverage effective dates). However, pursuant to 45 CFR §155.400(e)(1)(iii), as with other retroactive effective dates, if a consumer only pays a premium for one month of coverage, only prospective coverage should be effectuated, in accordance with regular effective dates.

Individuals subject to SEP verification have their enrollment "pending" until the FFEs complete verification of SEP eligibility either through automated electronic means or based on documentation that the individual submits. The requirement to verify SEP eligibility is referred to as an SEP verification issue (SVI).³⁰ If the FFEs cannot automatically verify an individual's SEP eligibility, then the individual must submit documentation within 30 calendar days of plan selection in order to verify eligibility. Once an individual's SEP eligibility has been verified, the FFEs will release their enrollment information to the relevant issuer. SEP verification currently applies to the following SEP types: Loss of qualifying coverage; permanent move; marriage; gaining or becoming a dependent through an adoption, foster care placement, or other court order; and Medicaid or Children's Health Insurance Program (CHIP) denial.

6.2 Plan Category Limitations for SEPs

The 2017 Market Stabilization Rule also provided that while existing FFE enrollees are not subject to

²⁹ <https://www.regulations.gov/document?D=CMS-2017-0021-4021>

³⁰ <https://marketplace.cms.gov/technical-assistance-resources/sep-preenrollment-verification-overview.pdf>

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SEP verification, they may be limited in their ability to change plans during the benefit year if they qualify for an SEP. This plan category limitations (PCL) policy was codified in regulation at 45 CFR §155.420(a)(3) and (4). It applies to individuals who enroll in Exchange coverage, but not to those enrolling in individual market coverage off-Exchange. The FFEs implemented PCL in February 2019; implementation timelines in SBEs may vary. Direct Enrollment (DE) partners that process enrollments through SEPs must implement functionality to ensure enrollees subject to PCL can only see plans for which they are eligible, and those requirements can be found in the DE Application Programming Interface (API) specs at <https://zone.cms.gov/document/direct-enrollment-de-documents-and-materials>.

6.3 PCL Background

Health plans sold in the Exchange are divided into categories: Bronze, Silver, Gold, and Platinum. They range from Bronze plans, which have lower premiums and higher out-of-pocket costs, to Platinum plans, which have higher premiums and lower out-of-pocket costs. Catastrophic plans, which have lower monthly premiums and higher out-of-pocket costs, and which are not eligible for PTC, may also be available to people under age 30 and people who qualify for hardship exemptions.

Under PCL, enrollees who qualify for most SEP types and want to change plans during the year will have a limited number of plan categories to choose from. This means if an enrollee wants to change plans during an SEP for which they qualify, they may need to select a new plan within the same plan category as their current plan, or wait until the next OEP if they want to change to a plan in a different category.

- If an enrollee becomes newly eligible for cost-sharing reduction (CSR) and is not already enrolled in a Silver plan, that enrollee can choose a plan in the Silver category to use their CSR.
- If an enrollee gains a dependent due to marriage, birth, adoption, foster care, or court order, he or she can add the new dependent to their current plan or enroll the new dependent in a plan of any plan category. To enroll the new dependent in a plan of any plan category, the enrollee must create a separate enrollment group for their dependent before proceeding to Plan Compare to view all plans available to the new dependent.
NOTE: Under these SEPs for gaining a dependent, only the new dependent may enroll in a plan of any plan category. Current enrollees generally cannot change plans.
- If an enrollee wishes to add a new dependent to the current plan, but the current plan's business rules do not allow it, the enrollee and dependent can enroll together in a different plan in the same category. If no other plans are available in the same category as the current plan, the enrollee can enroll together with the new dependent in a limited range of categories. For example, if the enrollee's existing Gold plan does not allow him or her to add a new dependent, and no other Gold plans are available, the enrollee and dependent can enroll together in a Platinum or Silver plan.

For more details about PCL rules by SEP type, see Exhibit 14.

6.4 Availability and Length of SEPs

The FFEs determine whether an individual is eligible for an SEP based on a qualifying event described in 45 CFR §155.420(d). Pursuant to 45 CFR §155.420(c), unless otherwise stated, SEPs in the FFEs and other Exchange individual markets last 60 days from the date of the triggering event. Exceptions

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to the 60-day availability period include:

- Certain SEPs for which the FFEs may define the length of the SEP based on the circumstances, such as SEPs related to enrollment errors, exceptional circumstances, and misrepresentation.³¹ The SEPs for these situations may last less than 60 days, depending on the specific situation, but will not last for longer than 60 days.

In addition, the FFEs offer advanced availability of the SEP for loss of minimum essential coverage (MEC) for QIs or their dependents, so these individuals have up to 60 days before and up to 60 days after the loss of coverage to report a qualifying event and select a QHP. The FFE also offers advanced availability of the SEP for QIs or their dependents who newly gain access to an individual coverage Health Reimbursement Arrangement (HRA) (sometimes referred to as an “ICHRA”) or are newly provided a qualified small employer Health Reimbursement Arrangement (QSEHRA). Individuals eligible for this individual coverage HRA/QSEHRA SEP have 60 days before the triggering event to select a QHP, unless the individual coverage HRA or QSEHRA was not required to provide the notice setting forth its terms to such enrollee at least 90 days before the beginning of the plan year, in which case the QI or their dependent has 60 days before or after the triggering event to select a QHP.

Exchanges have the option to offer advanced availability to QIs and enrollees who qualify for an SEP due to a permanent move, becoming newly eligible for premium tax credits (PTC) as a result of a move or increase in income above 100% Federal Poverty Level (FPL), or becoming newly eligible for QHP coverage; however, the FFEs do not currently offer advanced availability for these SEPs.

- SEPs in the FF-SHOP may apply differently and have different availability periods (see 45 CFR §155.726(c) and Section 4.4).

6.5 SEP Triggering Events and Coverage Effective Dates

Individuals may qualify for an SEP under 45 CFR §155.420(d) based on certain “triggering events.” Certain SEPs are available to all QIs who experience a triggering event, while others are only available to current enrollees, or individuals who previously had MEC. Most triggering events apply to all individual (FFE and SBE) and SHOP Exchanges, however, in some cases triggering events are not applicable in the FF-SHOP or are at the option of the Exchange, and therefore may not be operationalized outside of the FFEs. Please see Exhibit 14 for a description of the applicability of each SEP. For more information on SEPs that apply only to the SHOP Exchanges, please see Section 4.4 and 45 CFR §155.726(c).

Coverage effective dates for individuals who enroll through an SEP are established in 45 CFR §155.420(b) and apply to SEPs offered in individual and SHOP Exchanges.

The FFE has established a deadline of March 31st each year for submission of new requests for an SEP that would enable consumers to enroll in a QHP with effective dates for the prior coverage year. After March 31st of each year, new FFE SEP requests eligible for a retroactive effective date will be given a coverage effective date no earlier than January 1st of the current year, with the exception of the SEPs described at 45 CFR §155.420(d)(4), (d)(9), and (d)(11). For example, if a consumer submits an SEP request on April 7 that would otherwise entitle the consumer to enroll in prior year coverage,

³¹ See 45 CFR §155.420(c)(3). In the case of QIs/enrollees eligible for an SEP based on criteria in 45 CFR §155.420(d)(4), (d)(5), or (d)(9), the Exchange may define the length of the SEP “as appropriate based on the circumstances of the SEP, but in no event shall the length of the SEP exceed 60 days.”

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the applicant will be granted an effective date of January 1. This guidance does not apply to eligibility appeals and does not impact a consumers' right to request an appeal of their eligibility determination in accordance with 45 CFR §155.505(b).

6.5.1 Regular Coverage Effective Dates

As described in 45 CFR §155.420(b)(1), **regular coverage effective dates** for enrollment during an SEP are the first day of the month following QHP selection if selection took place between the first and 15th day of any month or the first day of the second month following QHP selection if selection took place between the 16th and the last day of any month. Beginning in January 2022, SEPs currently following regular effective date rules will instead be effective on the first of the month following plan selection in FFEs.

6.5.2 Other Coverage Effective Dates

Pursuant to 45 CFR §155.420(b)(2)(i), for a QI who gains a dependent or becomes a dependent through birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order, an Exchange must offer coverage **retroactive** to the date of birth, adoption, placement for adoption or in foster care, or the date of the child support or other court order. QIs may also elect a later coverage effective date (either the first of the month following plan selection, or in accordance with paragraph (b)(1)) by calling the Marketplace Call Center.

Pursuant to 45 CFR §155.420(b)(2)(iii), for certain SEP triggering events, an Exchange may provide for a coverage effective date that is appropriate based on the circumstances of the SEP. For example, when individuals or enrollees have experienced an Exchange error that impacts their enrollment or non-enrollment in coverage (per 45 CFR §155.420(d)(4)), they will be given the option for a retroactive coverage effective date back to their initially intended coverage effective date, absent the error.

45 CFR §155.420(b)(2)(iv) provides that certain SEPs offer “**accelerated coverage effective dates**,” which is the date of the first day of the month following the triggering event, if the plan selection is made on or before the day of the triggering event, regardless of whether plan selection takes place in the first or second half of the month. If plan selection is made after the date of the triggering event, the Exchange has the option to provide regular effective dates or to provide that coverage take effect the first of the month following plan selection (see Exhibit 14 for more detail on which rule applies in the FFEs based on triggering event). For example, individuals or enrollees who qualify for an SEP due to a loss of MEC (per 45 CFR §155.420(d)(1) or (d)(6)(iii)) may be eligible to enroll in coverage with an accelerated coverage effective date. 45 CFR §155.420(b)(2)(vi) applies to the SEP for individuals who newly gain access to an individual coverage HRA or to a QSEHRA, and provides for a similar accelerated coverage effective date rule to what is provided at (b)(2)(iv), but specifies that if the plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following plan selection.

Exhibit 14 summarizes the six categories of SEP triggering events from 45 CFR §155.420(d) as well as coverage effective dates for each SEP. It also includes information on:

- Whether the SEP is subject to pre-enrollment verification (SEP-V),

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- Whether the SEP is subject to PCL, and if so, what the specific limitation for the existing enrollee is,
- The applicability of the SEP to the FF-SHOP and other Exchanges,
- How QIs can access the SEP (i.e., through the FFEs application or through the Marketplace Call Center)
- SEP enrollment codes.

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Exhibit 14: SEP Triggering Events and Coverage Effective Dates Summary

SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Loss of qualifying health coverage	<p>(d)(1)(i-iv) – Loss of MEC</p> <p>* New Enrollees Subject to SEP-V</p> <p>** (d)(1)(ii) – The end of the plan year for any non-calendar year group health coverage – is not applicable in SHOP Exchanges</p> <p>**** Existing enrollees will generally be limited to plan options within their current plan category.</p>	<p>A QI or their dependent loses MEC, including but not limited to Medicaid, CHIP, or qualifying employer sponsored coverage.</p> <p>For purposes of qualifying for this SEP, this includes:</p> <ul style="list-style-type: none"> • The end of the plan year for any non-calendar year group health plan or individual health insurance coverage, including a non-calendar year individual coverage HRA or a QSEHRA; • Losing pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act or access to healthcare services through coverage provided to a pregnant woman's unborn child; and/or • Losing medically needy coverage described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. <p>NOTE: This does not include QIs who have lost their coverage due to nonpayment of premiums, voluntary termination, or as a result of an act of fraud by the QI (or other act that would qualify for rescission) (per 155.420(e)).</p> <p>Coverage Effective Dates:</p> <ul style="list-style-type: none"> • Plan selection after Loss of MEC: 1st of the month after plan selection. • Plan selection prior to or on the date of the Loss of MEC: 1st of the month following the loss of MEC. 	07	Application

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SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Loss of qualifying health coverage (continued)	<p>(d)(6)(iii) – Become newly eligible for advance payments of the premium tax credit (APTC) due to changes to current employer-sponsored coverage</p> <p>*New enrollees subject to SEP-V</p> <p>**Not applicable in SHOP Exchanges</p> <p>****Existing enrollees will generally be limited to plan options within their current plan category.</p>	<p>A QI or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3).</p> <p>Coverage Effective Dates:</p> <ul style="list-style-type: none"> • Plan selection after loss of MEC: 1st of the month after plan selection. • Plan selection prior to or on the date of the loss of MEC: 1st of the month following the loss of MEC. 	07	Application

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SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Change in household size	<p>(d)(2)(i) – Gain a dependent or become a dependent</p> <p>*New enrollees subject to SEP-V if gaining/becoming a dependent through marriage, adoption, placement for adoption, placement in foster care, or a child support or other court order. (New enrollees gaining a dependent through birth are not currently subject to SEP-V.)</p> <p>**The SEP at (d)(2)(ii) – Loss of dependent due to divorce, legal separation or death is offered at the option of the Exchange and is not currently available in the FFEs.</p> <p>***Existing enrollees will generally be limited to their current plan.</p>	<p>A QI gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.</p> <p>Coverage Effective Dates:</p> <ul style="list-style-type: none"> • Marriage: 1st of the month after plan selection. • Birth, adoption, foster care placement, court order: Retroactive back to the date of the event. <p>NOTE: For birth, adoption, placement for adoption, or placement in foster care, or court order, individuals may alternatively request a coverage effective date of the first day of the month following the date of plan selection or following regular prospective coverage effective dates by calling the Marketplace Call Center.</p> <p>NOTE: For marriage, at least one spouse must have MEC as described for one or more days during the 60 days preceding the date of marriage, or meets one of the following criteria: lived for one or more days during the 60 days preceding the qualifying event in a foreign country or a United States territory; or lived for one or more days during the 60 days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no QHP's were available on the Exchange; or is an Indian as defined by Section 4 of the Indian Health Care Improvement Act. This requirement does not apply in the FF-SHOP. Verification of this requirement has not yet been implemented in the FFEs.</p>	<p>Birth: 02</p> <p>Marriage: 32</p> <p>Adoption/ Foster Care Placement/ Court Order: 05</p>	Application

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SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Change in primary place of living	<p>(d)(7) – Gain access to new QHPs due to a permanent move</p> <p>*New enrollees subject to SEP-V</p> <p>**Existing enrollees will generally be limited to plan options within their current plan category.</p>	<p>A QI or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move. The QI, enrollee, or dependent must also have had MEC for one or more days in the 60 days prior to the move, unless he or she meets one of the following criteria: lived for one or more days during the 60 days preceding the qualifying event in a foreign country or a United States territory; or lived for one or more days during the 60 days preceding the qualifying event or during their most recent preceding enrollment period, in a service area where no QHP's were available on the Exchange; or is an Indian as defined by Section 4 of the Indian Health Care Improvement Act.</p> <p>NOTE: Moving solely for medical treatment or vacation would not be considered a permanent move for purposes of qualifying for this SEP.</p> <p>Coverage Effective Dates: Regular prospective coverage effective dates.</p> <p>NOTE: At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFEs do not offer advanced availability for this SEP at this time.</p>	43	Application
Change in eligibility for Exchange coverage or help paying for coverage	<p>(d)(3) – Become newly eligible for QHP coverage</p> <p>*Not applicable in SHOP Exchanges</p> <p>**Existing enrollees will generally be limited to plan options within their current plan category.</p>	<p>A QI or their dependent becomes newly eligible for enrollment in a QHP due to gaining status as a citizen, national, or lawfully present individual or being released from incarceration.</p> <p>NOTE: QIs who change from one legally present status to another do not qualify for this SEP.</p> <p>Coverage Effective Dates: Regular prospective coverage effective dates.</p> <p>NOTE: At the option of the Exchange, this SEP can be available 60 days prior to the change in eligibility for QHP coverage. However, the FFEs do not offer advanced availability for this SEP at this time.</p>	NE	Application

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SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Change in eligibility for Exchange coverage or help paying for coverage (continued)	<p>(d)(6)(i-ii) – Become newly eligible or ineligible for APTC, or experience a change in eligibility for CSR</p> <p>*Not applicable in SHOP Exchanges</p> <p>**Current enrollees who are newly eligible for CSR are generally limited to either current plan category or Silver plans.</p>	<p>An enrollee or their dependent is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR.</p> <p>NOTE: This SEP is only available to current Exchange enrollees.</p> <p>Coverage Effective Dates: Regular prospective coverage effective dates.</p>	FC	Application
Change in eligibility for Exchange coverage or help paying for coverage (continued)	<p>(d)(6)(iv) – Previously in the coverage gap and become newly eligible for APTC</p> <p>*Not applicable in SHOP Exchanges</p> <p>**Existing enrollees will generally be limited to plan options within their current plan category.</p>	<p>A QI who was previously ineligible for APTC solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the QI becoming newly eligible for APTC.</p> <p>Coverage Effective Dates: Regular prospective coverage effective dates.</p> <p>NOTE: At the option of the Exchange, this SEP can be available 60 days prior to the move. However, the FFEs do not offer advanced availability for this SEP at this time.</p>	EX	CMS Caseworker via Marketplace Call Center
Change in eligibility for Exchange coverage or help paying for coverage (continued)	<p>(d)(6)(v) – Off-Exchange enrollee experiences a decrease in household income and new determination of eligibility for APTC</p> <p>*New enrollees are subject to SEP-V (to verify decrease in income and prior coverage)</p> <p>**Not applicable in SHOP Exchanges</p>	<p>At the option of the Exchange, a QI and their dependent who experiences a decrease in household income and is 1) newly determined eligible for APTC by an Exchange, and 2) had MEC as described in 26 CFR §1.5000A-1(b) for one or more days during the 60 days preceding the Change in Circumstance (CIC).</p> <p>Coverage Effective Dates: Regular prospective coverage effective dates.</p>	EX	CMS Caseworker via Marketplace Call Center

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SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Change in eligibility for Exchange coverage or help paying for coverage (continued)	(d)(8)(i-ii) – Gain or maintain status as a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation	<p>A QI who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, gains or maintains such status and may enroll in a QHP or change from one QHP to another one time per month.</p> <p>A QI who is or becomes a dependent of an Indian and is enrolled or is enrolling in a QHP through an Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian.</p> <p>Coverage Effective Dates: Regular prospective coverage effective dates.</p>	NE	Application
Enrollment or plan error	(d)(4) – Experience an error of the Exchange	<p>A QI's or their dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.</p> <p>Coverage Effective Dates: Appropriate date based on the circumstances of the SEP. Typically, retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective coverage effective date, at the option of the QI.</p> <p>NOTE: There are some exceptions for certain types of errors.</p>	EX	Marketplace Call Center
Enrollment or plan error (continued)	(d)(5) – Experience a plan contract violation	<p>An enrollee or their dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.</p> <p>Coverage Effective Dates: Appropriate date based on the circumstances of the SEP. Typically retroactive back to the coverage effective date the QI would have gotten absent the error or regular prospective coverage effective date, at the option of the QI.</p>	EX	CMS Caseworker

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SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Enrollment or plan error (continued)	(d)(12) – Material error related to plan benefits, service area, or premium	<p>The QI, enrollee, or their dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the</p> <p>QI https://www.law.cornell.edu/definitions/index.php?width=840&Bheight=800&Biframe=true&Bdef_id=8d07c7e6e67b5ce1046c828057738e0f&Bterm_occur=36&Bterm_src=Title%3A45%3AChapter%3AA%3ASubchapter%3AB%3APart%3A155%3ASubpart%3AE%3A155.420's or enrollee's decision to purchase a QHP through the Exchange.</p> <p>Coverage Effective Dates: Appropriate date based on the circumstances of the SEP. Typically, retroactive back to the coverage effective date the QI would have gotten absent the material error or regular prospective coverage effective date, at the option of the QI.</p>	EX	CMS Caseworker
Other qualifying changes	(d)(9) – Experience an exceptional circumstance	<p>A QI's, enrollee's, or their dependent's, enrollment or non-enrollment in a QHP is the result of an exceptional circumstance, as determined by the Secretary of HHS, including being incapacitated or experiencing a natural disaster.</p> <p>The enrollment or non-enrollment of a QI, enrollee, or their dependent in a QHP is the result of an unforeseen event or reflects a first-time requirement for Exchange enrollees (such as the Tax Season SEP for individuals impacted by the individual shared responsibility payment).</p> <p>The enrollment or non-enrollment of a QI, enrollee, or their dependent, enrollment or non-enrollment in a QHP is the result of a significant life event resulting in lack of access to their application or account and the individual, enrollee, or dependent has experienced a change in situation or status that now requires that he or she obtain MEC. This includes victims of domestic abuse or spousal abandonment. This also includes AmeriCorps servicemen and women who are starting or ending their service.</p> <p>Coverage Effective Dates: Vary based on circumstances.</p>	EX	CMS Caseworker, Marketplace Call Center (in some cases, Application)

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SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Other qualifying changes (continued)	(d)(10) – Domestic abuse/Spousal abandonment	<p>A QI is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2, including a dependent or unmarried victim within a household, is enrolled in MEC and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment.</p> <p>A dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim</p> <p>Coverage Effective Dates: Regular prospective coverage effective dates.</p>	EX	Marketplace Call Center
Other qualifying changes (continued)	<p>(d)(13) – Resolution of data matching issue (DMI) or verification of citizenship/lawful presence status</p> <p>*This SEP is offered in the FFEs but is optional for Exchanges.</p> <p>** Not applicable in SHOP.</p>	<p>The QI provides satisfactory documentary evidence to verify their eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in §155.315 or is under 100% of the FPL and did not enroll in coverage while waiting for HHS to verify their citizenship status as a national or lawful presence.</p> <p>Coverage Effective Dates: Appropriate date based on the circumstances of the SEP. Typically, retroactive coverage is back to date of termination.</p>	NE	Marketplace Call Center

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SEP Category	Regulatory Authority under 45 CFR §155.420	SEP Description from Regulation	Enrollment Code	Accessed Through
Other qualifying changes (continued)	(d)(14) – Newly gains access to an individual coverage HRA, or newly provided with a QSEHRA	<p>The QI, enrollee, or dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)), or is newly provided a QSEHRA, as defined in section 9831(d)(2) of the Internal Revenue Code.</p> <p>A QI, enrollee, or dependent will qualify for this SEP regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as they are not enrolled in the individual coverage HRA or provided the QSEHRA on the day immediately prior to the triggering event, which is the first day on which coverage under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect.</p> <p>Coverage Effective Dates:</p> <p>Individuals who qualify for this SEP have 60 days before their HRA start date to select a QHP, unless the HRA was not required to provide the notice setting forth its terms to them at least 90 days before the beginning of the plan year, in which case they have 60 days before or after their HRA start date to select a QHP.</p> <ul style="list-style-type: none"> Plan selection prior to triggering event: 1st of the month following the triggering event; if the triggering event is on the first day of a month, on the date of the triggering event. Plan selection on or after triggering event: 1st of the month after plan selection. 	<p>Individual coverage HRA: HR</p> <p>QSEHRA: QS</p>	Application

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Exhibit 15 provides examples of coverage effective dates for various SEPs within the FFEs.

Exhibit 15: SEP Effective Date Examples

Triggering Event	Triggering Event Date	SEP Start Date	SEP End Date (FFE – 60 days)	Plan Selection Date Examples	Enrollment Effective Dates
<i>Permanent Move</i> ♦	4/1	4/1	5/31	4/15	5/1
<i>Permanent Move</i> ♦	4/10	4/10	6/8	4/25	6/1
<i>Permanent Move</i> ♦	4/1	4/1	5/31	4/15	6/1
<i>Birth</i> *	6/1	6/1	7/31	6/29	6/1, 7/1 or 8/1
<i>Birth</i> *	8/25	8/25	10/23	9/15	8/25 or 10/1
<i>Birth</i> *	12/26	12/2	2/24	1/13	12/26, or 2/1
<i>Loss of Coverage</i> †	4/28	2/27	6/27	3/10	5/1
<i>Loss of Coverage</i> †	4/15	2/14	6/14	5/20	6/1
<i>Loss of Coverage</i> †	5/12	3/13	7/11	6/7	7/1
<i>Denied Medicaid/CHIP eligibility</i> **	4/28	4/28	6/27	5/20	6/1
<i>Denied Medicaid/CHIP eligibility</i> **	5/12	5/12	7/10*	7/10	8/1
<i>Marriage</i>	4/12	4/12	6/11	4/29	5/1
<i>Marriage</i>	7/1	7/1	8/30	7/20	8/1

♦ Per 45 CFR §155.420(c)(2), an Exchange has the option of offering the permanent move SEP to eligible consumers 60 days before the trigger event. This option is not available through the FFEs at this time.

*Per 45 CFR §155.420(b)(2)(i), the Exchange is required to ensure that coverage is effective for a QI or enrollee on the date of birth, adoption, placement for adoption, placement in foster care, or effective date of the child support order or other court order. However, QIs may also call the Marketplace Call Center to alternatively elect a coverage effective date for the first of the month following plan selection or following regular coverage effective rules.

†Per 45 CFR §155.420(c)(2)(i), QIs eligible for loss of coverage SEPs have up to 60 days before or up to 60 days after the triggering event to select a QHP.

**This SEP applies to individuals who applied for coverage during the OEP or due to a qualifying event and then were determined ineligible for Medicaid or CHIP outside of the enrollment period during which they applied.

NOTE: For individuals who are eligible for this SEP, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the SEP. These individuals generally can request a retroactive coverage effective date back to the coverage effective date they would have received if the FFEs had originally determined them eligible for QHP coverage.

6.6 SEPs Accessed Outside of the Application Process

The Exchange grants most SEPs through application questions or internal logic on the application. However, there are certain SEPs that eligible individuals must access through the Marketplace Call Center and, in some cases, by then having their information reviewed by a CMS Caseworker. These include:

- **Error of the Exchange or Misrepresentation in Enrollment Process SEP** (granted under 45 CFR §155.420(d)(4))
- **Experience a Plan or Contract Violation** (granted under 45 CFR §155.420(d)(5))
- **Material error related to plan benefits, service area, or premium** (granted under 45 CFR §155.420(d)(12))
- **Exceptional circumstance SEPs** (granted under 45 CFR §155.420(d)(9))

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- **Victim of domestic abuse or spousal abandonment** (granted under 45 CFR §155.430(d)(10))

Some of these SEPs, such as the Exchange error and exceptional circumstance SEPs, can be granted when QIs have not yet enrolled in a QHP, while others, such as material errors or some misrepresentation SEPs, may be granted after an enrollment has been effectuated.

Individuals seeking one of these SEPs will need to call the Marketplace Call Center and explain their situation. Call center representatives may be able to determine whether an individual is eligible for an SEP, but in many situations, they forward cases to CMS Caseworkers to determine the individual's eligibility for an SEP. If the SEP is granted and a new enrollment is processed, a record is assigned to the issuer through the Health Insurance Casework System (HICS) directing the issuer to change the coverage effective date, if applicable.

To terminate prior coverage on a date that will align with the new coverage effective date, the issuer will need to honor an enrollee's request to terminate their prior coverage the day before the new QHP's coverage effective date, pursuant to 45 CFR §155.430(d)(6).

6.7 Exceptional Circumstances SEPs

Exceptional circumstances SEPs authorized by 45 CFR §155.420(d)(9) are generally reviewed on a case-by-case basis. However, CMS had identified some specific cases and parameters for which an Exceptional circumstances SEP is available, and they are outlined in more detail in this section.

*SEP for QIs Affected by Emergencies and Major Disasters*³²

Typically, individuals have 60 days from the date of a SEP qualifying event to enroll in a QHP. However, if an individual or his or her dependents are affected by an emergency or major disaster that is recognized with a formal declaration from the Federal Emergency Management Agency (FEMA) and that emergency or major disaster prevents the individual or his or her dependents from enrolling within 60 days of the qualifying event, or from enrolling during the OEP, the individual and his or her dependents will be eligible for an Exceptional Circumstances SEP under 45 CFR §155.420(d)(9) that allows them to complete their Exchange enrollment.

Individuals will be considered "affected by a FEMA-declared emergency or major disaster" and eligible for an Exceptional Circumstances SEP under 45 CFR §155.420(d)(9) if they were unable to enroll during an enrollment period for which they were eligible for, that is, either the OEP or an SEP, due to a FEMA-declared emergency or disaster. To demonstrate this, individuals are required to attest that they meet the following eligibility requirements: 1) they resided in any of the counties eligible to apply for "individual assistance" or "public assistance" by FEMA either during the FEMA-designated incident period of the emergency or major disaster or at the time of application for enrollment, and 2) they were affected by the emergency or disaster and that it prevented them from completing enrollment.

FEMA-emergency affected individuals have up to 60 days from the end of the FEMA-designated incident period to select a new QHP through the FFE or make changes to their existing QHP enrollment. FEMA-emergency affected individuals can choose to have their coverage start prospectively, pursuant to regular effective date rules under §155.420(b)(1), or can request an effective date that would have been applied if they had selected a plan during their original enrollment opportunity. Finally, coverage effective date rules

³² A full copy of this guidance is available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf>.

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vary based on the date of plan selection and the qualifying event for the enrollment opportunity.

For example, Mary Smith's employer-sponsored health insurance coverage ended on June 1. Because Mary lost minimum essential coverage (MEC), she qualifies for an SEP under 45 CFR §155.420(d)(1)(i) and has 60 days from the loss of MEC, through July 31st, to select a QHP. However, Mary was unable to complete her FFE application and QHP selection by July 31st because a severe tropical storm flooded the ground floor of her home in Mobile County, Alabama (AL). She stayed with relatives in nearby Clark County for several days until the flood waters receded, and then spent the next several weeks cleaning up the damage.

On July 7th, FEMA announced a Major Disaster Declaration related to the storm and flooding, with an incident period of June 20th-22nd. FEMA designated several AL counties, including Mobile, as eligible to apply for public assistance. As such, even though her SEP for loss of MEC has expired, Mary is now eligible for an Exceptional Circumstances SEP under 45 CFR §155.420(d)(9) and may apply for and select FFE coverage through August 21st (60 days from June 22nd). If Mary selects a QHP between August 1st and August 15th, she will be eligible to start coverage prospectively (on September 1st, per regular effective date rules) or in the past (on July 1st or August 1st—effective dates that would have been available if she had chosen a plan during the loss of MEC SEP window but after June 20th, the FEMA incident start date). Additionally, if Mary selects a plan under this Exceptional Circumstances SEP between August 16th and August 21st, she will be eligible to start retroactive coverage on July 1st or August 1st (effective dates that would have been available if she had chosen a plan during the loss of MEC SEP window, but after June 20th, the FEMA incident start date), or choose to start coverage in the future, on October 1st, per regular effective date rules.

Exhibit 16 provides additional samples of qualifying events and coverage dates for FEMA-emergency affected individuals.

Exhibit 16: Sample SEP Coverage Effective Dates for FEMA-Emergency Affected Individuals

Qualifying Event	Date of Qualifying Event	Qualifying Enrollment Period End Date	FEMA Incident Start Date	FEMA Incident End Date	Exceptional Circumstance SEP End Date	Plan Selection Date Example	Available Coverage Effective Date(s)
Birth or Adoption*	6/1	7/31	6/20	6/22	8/21	8/3	6/1, 7/1, 8/1, or 9/1
Birth or Adoption*	6/1	7/31	7/5	7/23	9/22	9/21	6/1, 8/1, 9/1, or 11/1
Loss of Coverage	6/1	7/31	6/20	6/22	8/21	8/5	7/1, 8/1, or 9/1
Loss of Coverage	6/23	8/22	6/20	7/22	9/21	9/3	7/1, 8/1, 9/1 or 10/1
Annual OEP	n/a	12/15	11/2	11/15	1/14	12/19	1/1 or 2/1
Annual OEP	n/a	12/15	11/30	12/10	2/9	2/3	1/1 or 3/1

*Per 45 CFR §155.420(b)(2)(i), the Exchange is required to ensure that coverage is effective for a QI on the date of birth, adoption, placement for adoption, placement in foster care, or effective date of the child

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support order or other court order. However, QI may also call the Marketplace Call Center to alternatively elect a coverage effective date for the first of the month following plan selection or following regular coverage effective rules.

To apply for an Exceptional Circumstances SEP, FEMA-emergency affected individuals must contact the Marketplace Call Center at 1-800-318-2596 (TTY:1-855-889-4325) and indicate they were eligible for another enrollment window, but were unable to complete their enrollment due to a FEMA-designated emergency or disaster. To expedite this process, FEMA-emergency affected individuals can complete an application on HealthCare.gov directly or with the assistance of a Navigator, Agent or Broker, Certified Application Counselor (CAC), or DE Partner, before calling the Marketplace Call Center.

SEP for AmeriCorps/VISTA/National Civilian Community Corps Members³³

The Corporation for National and Community Service (CNCS), which is a Federal agency, manages and provides grants for the AmeriCorps State and National, VISTA, and National Civilian Community Corps (NCCC) programs. These programs provide funding and other support for individuals engaged in national service, and CNCS is required to ensure that the members in these programs have health coverage.

CNCS and its AmeriCorps programs do not provide group health plan coverage to members because members do not have an employment relationship with either CNCS or its grantees. Therefore, CNCS encourages AmeriCorps members to consider seeking coverage through the FFE or SBEs.³⁴ However, many members begin and end their terms of service outside of the OEP, and other who members receive short-term, limited-duration coverage or self-funded coverage as part of their AmeriCorps service are not able to access QHP coverage in the FFE outside of OEP upon completion of their service as this coverage is not MEC and does not qualify members for the loss of MEC SEP.

In accordance with 45 CFR 155.420(d)(9), and in light of the statutory obligation for health coverage to be provided to the participants in the AmeriCorps State and National, CMS determined that participants and their dependents in the AmeriCorps State and National, VISTA, and NCCC programs are eligible for the Exceptional Circumstances SEP. This SEP applies for individuals who are 1) beginning service in the AmeriCorps State and National, VISTA, or NCCC programs; or 2) individuals who are concluding their service in the AmeriCorps State and National, VISTA, or NCCC programs and are losing access to their short-term, limited-duration coverage or self-funded coverage.

Affected AmeriCorps State and National, VISTA, and NCCC members have 60 days from their triggering event, defined as either the date they begin service, or the date they lose access to short-term, limited-duration coverage or self-funded coverage from these programs, to select a QHP through the FFE. coverage effective dates will be prospective based on the date of plan selection and these individuals should contact the Marketplace Call Center to request this SEP. They should inform the Marketplace call center that they are beginning or concluding service with AmeriCorps State and National, VISTA, or NCCC.

6.8 Plan Display Errors

Plan display errors occur when an issuer or Exchange error or change causes HealthCare.gov to display incorrect and potentially disadvantageous plan data to QIs. This can include, but is not limited to, premium, benefits, and cost-sharing errors or changes that display directly on HealthCare.gov. Plan

³³ See <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf>.

³⁴ For example, see <https://www.nationalservice.gov/programs/ameri-corps/current-members/health-care-options>.

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display errors or changes that are made to external websites will not be considered triggering events for plan display error SEPs, but in certain circumstances may qualify a QI for an SEP under 45 CFR §155.420(d)(5). QIs affected by plan display errors or changes may be eligible for an SEP under 45 CFR §155.420(d)(12) to return to the Exchange and select another QHP.

QIs eligible for a plan display error SEP under 45 CFR §155.420(d)(12) are typically already enrolled in a QHP, which requires the SEP process to accommodate the additional complexity of terminating enrollment in the original QHP if a QI enrolls in a different QHP during the SEP period. Additionally, QIs generally need to be notified of their eligibility for this SEP.

As we clarified in the HHS Notice of Benefit and Payment Parameters for 2018 Final Rule,³⁵ this SEP only applies to material plan or benefit display errors or changes made through the Exchange and does not include plan or benefit display errors or changes made outside of the Exchange. This SEP is intended for consumers who made the decision to purchase health coverage through the Exchange and their decision about which QHP to enroll into was impacted by this material plan or benefit display error. Through existing data correction processes, the Exchange will typically be made aware of these errors and any corrections that were made. For other plan errors that may exist outside of the Exchange, CMS will consider whether the error constitutes a material contract violation that would be eligible for an SEP pursuant to 45 CFR §155.420(d)(5).

In addition, provider directory and drug formulary errors and changes will not be considered triggering events for plan display error SEPs, regardless of whether they display on external websites or on HealthCare.gov. In these cases, other consumer protections might apply. For instance, if a drug is no longer on the plan's formulary, the plan is still required to have processes in place that allow the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by a health plan (a request for exception) in accordance with 45 CFR §156.122(c). For this reason, these cases do not qualify a consumer for the plan display error SEP.

6.8.1 Identifying and Resolving Plan Errors

Plan display errors are identified after CMS investigates potential display discrepancies on HealthCare.gov identified by issuers, QIs, or by CMS. Exchange plan display errors include situations where coding on HealthCare.gov causes benefits to display incorrectly, or where CMS identifies an incorrect QHP data submission or discrepancy between an issuer's QHP data and its state-approved form filings. If a coding error is identified, CMS determines whether other QHPs are affected by the same error and reaches out to other affected issuers. When a plan display error is identified on HealthCare.gov, CMS works with the issuer to correct the error as quickly as possible to ensure enrollments moving forward are based on accurate plan data. These errors are often corrected during data correction windows (DCWs). Once corrected, the data on HealthCare.gov will be updated to reflect the correct data and CMS will work with the issuer to notify impacted QIs. As discussed above, errors or changes made on external websites and documents linked on HealthCare.gov will not be considered triggering events for plan display error SEPs (i.e., corrections or updates to provider lists, drug formularies, or summaries of benefits and coverage).

CMS will consider the impact of the change on QIs who enrolled in the affected plan before it was corrected. In some cases, the corrected plan data either reduces a benefit or increases costs to QIs. If the

³⁵ 81 Fed. Reg. 94058, 94129 (Dec. 22, 2016).

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corrected plan data is a benefit or cost that displays on HealthCare.gov, CMS works with the issuer and state's Department of Insurance and the applicable state's regulatory authority to arrive at a solution that has a minimal impact on QIs and affirms, to the extent possible, that they are not negatively affected by this Exchange or issuer error.

Generally, the most straightforward and QI-friendly resolution is for issuers to honor the benefit as it was displayed incorrectly for affected enrollees, if permitted by the applicable state regulatory authority. If the issuer chooses to honor the benefit and administers the plan as it was incorrectly displayed for the affected enrollees, CMS will not provide enrollees with an SEP.

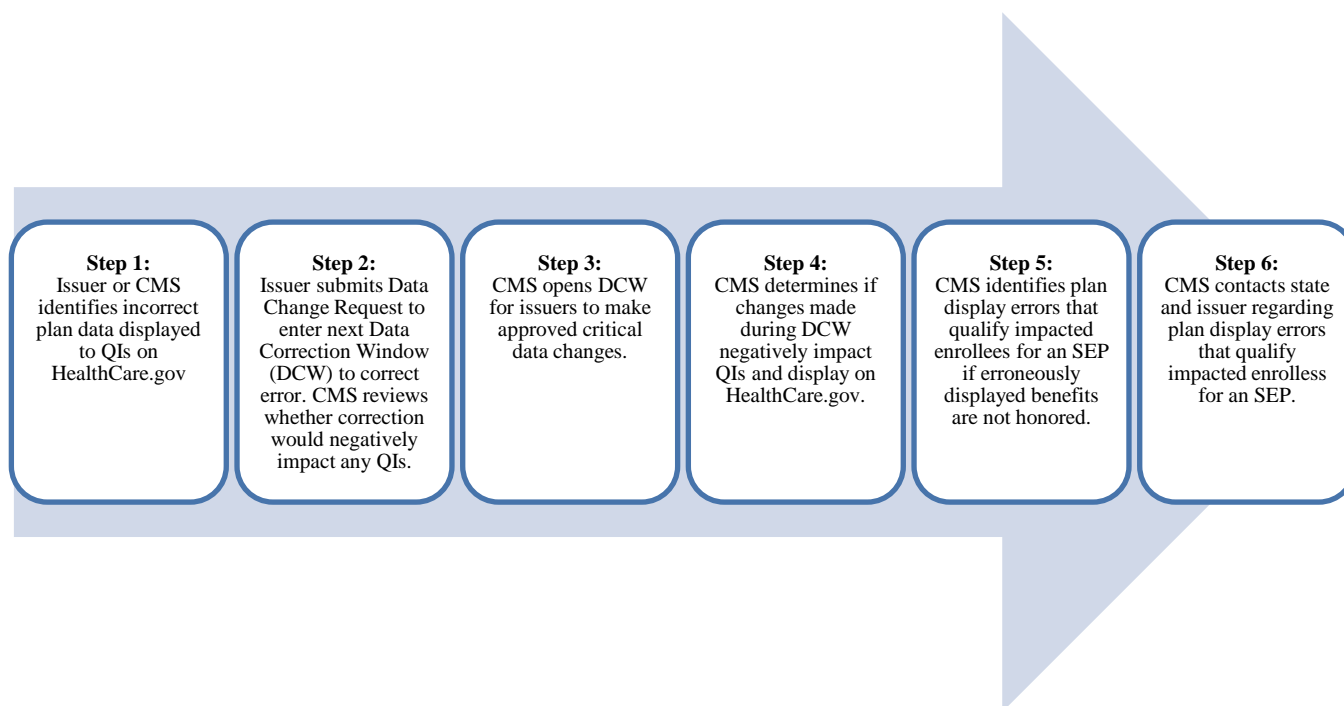
6.8.1.1 Issuers that Do Not Honor the Plan Information that Displayed Incorrectly

Depending on the significance of the plan display error, there are several options to mitigate the impact on the QI.

A plan display error is considered significant (i.e. a material error) if it is reasonable to expect that it has affected a QI's purchasing decision. For any such material plan display error, QIs are notified of the error and offered a plan display error SEP. The SEP will provide QIs with the option to select another plan, either from the same issuer or another issuer available to the QI, but does not require them to do so if they wish to stay enrolled in their existing plan with the correct benefits.

Exhibit 17 outlines the steps issuers take to identify and correct plan display errors and the process by which CMS reviews these changes for potential plan display error SEPs.

Exhibit 17: Identifying and Correcting Plan Display Errors That May Qualify for SEPs



6.8.2 Processing Plan Display Error SEPs

Under 45 CFR §156.1256, as of May 9, 2016, directed by the FFEs, issuers must notify their enrollees of material plan or benefit display errors and the enrollees' eligibility for an SEP within 30 calendar days

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after being notified by the FFEs that the error has been fixed, if directed to do so by the FFEs.

CMS allows an SEP-qualified individual already enrolled in a QHP to select a new QHP by calling the Marketplace Call Center. The Marketplace Call Center will help the QI update their information as needed and complete the process of selecting a QHP. QIs generally have 60 days from when they are notified by their issuer of the plan display error to select a new plan.

Under 45 CFR §155.420(b)(2)(iii), an Exchange may provide for a coverage effective date that is either: 1) based on the date of the SEP-triggering event, which provides the enrollee their initially intended coverage effective date; or 2) based on the date of the plan selection during the SEP window, which provides the enrollee regular effective dates under 45 CFR §155.420(b)(1).

In the case of a retroactive coverage date or retroactive termination date, the former issuer repays premiums and reverses claims payments. The gaining issuer collects premiums for all months of coverage and adjudicates the claims from previous months. With prospective coverage, QI's deductibles and accumulations towards the maximum out-of-pocket limit are reset starting with the new date of coverage.

The coverage effective date for the new QHP is communicated to the gaining issuer through HICS if it is different from what the system automatically assigns. The former issuer must terminate the coverage when the QI has selected another QHP during an SEP.

Exhibit 18 outlines action steps and the timeline that CMS and issuers follow to resolve plan display errors through the SEP process.

Exhibit 18: Resolving Plan Display Error SEPs

CMS Action Steps	Issuer Action Steps
<p>CMS takes following initial action steps:</p> <ul style="list-style-type: none"> Notifies issuer they made a change that requires either honoring the benefit or offering an SEP Advises issuer of the SEP process Provides sample QI and employer notice language to the issuer 	<p>Within five business days of CMS notification, the issuer:</p> <ul style="list-style-type: none"> Communicates to CMS its preference for either honoring the benefit or offering an SEP Provides draft QI and employer notices to CMS for review, if issuer prefers to offer an SEP <p>Within 10 business days of CMS notification, an issuer that prefers to honor the benefit rather than offer an SEP:</p> <ul style="list-style-type: none"> Provides CMS with evidence of state authorization to honor the benefit Takes no additional action steps unless notified otherwise
<p>Within two business days of issuer providing CMS with draft QI and employer notices for offering an SEP, CMS takes following action steps:</p> <ul style="list-style-type: none"> Reviews draft QI and employer notices Provides issuer with either approval or necessary revisions of draft notices 	<p>Within five business days of CMS approval, the issuer:</p> <ul style="list-style-type: none"> Sends approved notices to SEP-qualified enrollees and employers Sends notices, mailing date, and impacted enrollee count to CMS
<p>Upon receipt of notices, mailing date, and impacted enrollee account from issuer, CMS:</p> <ul style="list-style-type: none"> Sends notice, mailing date, and impacted enrollee count to the FF-SHOP Hotline 	<p>The issuer has completed its SEP action steps, unless notified otherwise.</p>

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7. PREMIUMS (APPLICABLE TO INDIVIDUAL MARKET FFEs, QHPs/QDPs)

7.1 Effectuation of Prospective Coverage Under Regular Coverage Effective Dates and Special Effective Dates

The Federally-Facilitated Exchanges (FFEs) have established guidelines regarding binder payments (typically the first month's payment) and issuer deadlines for payment of the binder payment. For prospective coverage to be effectuated under regular coverage effective dates, as provided for in 45 CFR §§155.410(f) and 155.420(b)(1), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date, and no later than 30 calendar days from the coverage effective date.

In instances where issuers are processing enrollments with prospective coverage to be effectuated under special effective dates, as provided for in 45 CFR §155.420(b)(2), such as in connection with gaining access to new QHPs as a result of a permanent move, getting married, or losing coverage, the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date, and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later.

For the purpose of enrollment in a QHP, issuers can set reasonable standards for determining when a payment is received, such as by considering payment received when an Electronic Fund Transfer (EFT) is completed, a credit or debit card transaction is processed, or a paper check or money order is in the issuer's possession (i.e., received and logged in the issuer's mailroom). See Section 7.3 for information on when an issuer may condition effectuation of a new enrollment on payment of past-due premium in addition to the required binder payment.

Binder for retroactive enrollments and the corresponding option for the enrollee's payment to adjust the start date of the policy depend on whether a special enrollment period (SEP) that is verified by the FFEs enabled the retroactive transaction.

7.1.1 Effectuation of Coverage with a Retroactive Effective Date Associated with an SEP that is Not Verified

For coverage to be effectuated under retroactive effective dates as provided for in 45 CFR §155.420(b)(2), such as error of the Exchange under §155.420(d)(4), the binder payment must consist of the premium due for all months of retroactive coverage through the first prospective month of coverage, and the deadline for making the binder payment must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction or Health Insurance Casework System (HICS) case establishing the retroactive start date. If the enrollee pays only the premium for one month of coverage by the deadline, only prospective coverage should be effectuated, in accordance with regular effective dates. The issuer must receive full payment (or payment within the premium payment threshold in accordance with 45 CFR §155.400(g) and Section 7.2, Premium Payment Threshold, if the issuer utilizes such a threshold) from the enrollee for any applicable binder payment by the applicable premium payment deadline. Issuers may not grant grace periods for payment of the binder payment.

When a qualified individual (QI) enrolls with a retroactive effective date, a prospective coverage effective date may be conveyed to the issuer via an 834 transaction due to technical constraints, and the retroactive

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coverage date identified via HICS. Based on timing of the receipt and processing of the associated HICS case, the issuer may have already billed the QI for the first month's premium for prospective coverage in accordance with 45 CFR §155.400(e)(1)(i), but should adjust the binder billing to reflect retroactive binder rules. If by the due date the QI pays at least the first month's premium but less than all outstanding premium due, subject to the issuer's payment threshold policy, if applicable, the QI's enrollment would be effectuated for prospective coverage. Once the issuer processes the HICS case and receives premiums due, the retroactive coverage can be effectuated, with the correct effective dates reported to the FFEs by the issuer via Enrollment Data Alignment.

When issuers add retroactive coverage to an already effectuated enrollment, the enrollee must pay all outstanding retroactive premium by the later of 1) the time period mandated by state rules, or 2) the issuer's stated due date. In the absence of more generous state regulations, CMS encourages issuers to allow at least one full billing cycle for enrollees to make such a payment of retroactive premium. Failure to pay outstanding premium on an effectuated enrollment that is not already in delinquency by the applicable due date would trigger the applicable grace period.

7.1.1.1 Examples of Binder for Non-Verified Retroactive Enrollments [155.400(e)(1)(iii)]

Example 7A: On June 10, the enrollee contacts the Marketplace Call Center to request an SEP pursuant to 45 CFR §155.420(d)(4). The enrollee informs the Marketplace Call Center that although he or she was enrolled in QHP B with a coverage effective date of January 1, he or she should have been enrolled in QHP A instead. The Marketplace Call Center sends their case to a member of the FFE casework team, who finds that the enrollee was enrolled in the wrong QHP. On July 2, the FFE sends the QHP B issuer a retroactive cancellation transaction. The QHP B issuer reverses the enrollee's submitted claims and refunds the premiums he or she paid for that year's coverage. Also, on July 2, the Exchange sends the QHP A issuer an 834 transaction enrolling the enrollee with a coverage effective date retroactive to January 1. The enrollee's share of premium after applying their advance payments of the premium tax credit (APTC) is \$100 per month. The QHP A issuer receives the 834 transaction on July 2, and, pursuant to 45 CFR §155.400(e)(1)(iii), bills the enrollee for all outstanding prospective and retroactive premiums (\$700 of premiums for retroactive coverage and \$100 of premiums for August, which will also be due before the binder due date), with a payment due date 30 calendar days from the date the issuer received the 834 transaction. Before the payment due date, the issuer receives payment of \$800 from the enrollee, and effectuates their coverage with a retroactive effective date of January 1.

Example 7B: A QI is eligible for retroactive enrollment in QHP A with the same dates as Example 7A. A prospective coverage effective date is conveyed to the issuer via an 834 transaction, but the retroactive coverage start date of January 1 is conveyed in an associated HICS case. Before the due date, the enrollee pays the QHP A issuer \$100 and makes no further payment. Since the QHP A issuer received the 834 enrollment transaction on July 1, the issuer effectuates the enrollment effective August 1, not January 1.

Example 7C: On July 14, a QI receives a final eligibility appeals decision finding that the QI should be granted an SEP to enroll in coverage based on a qualifying life event that occurred in February of that year. Upon receipt of the appeal decision, the QI enrolls in a QHP with a requested coverage effective date of March 1. Because this request for coverage with a retroactive effective date does not arise from an SEP subject to verification, the QI must pay premium in accordance with 45 CFR §155.400(e)(1)(iii), which states that the QI must pay a binder payment of premium due for all months of retroactive coverage, plus the first prospective month of coverage, or an amount sufficient to satisfy any applicable premium payment threshold, consistent with 45 CFR §155.400(g). The monthly member-responsible

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portion of premium is \$100. In order to effectuate coverage with an effective date of March 1, the QI must pay \$600, or an amount sufficient to satisfy any applicable premium payment threshold, consistent with 45 CFR §155.400(g), which would satisfy premium amounts for March through July and for the prospective month of August. By the binder payment deadline, the QI paid the QHP issuer only \$100. Under the rule at 45 CFR §155.400(e)(1)(iii), the QHP issuer should effectuate prospective coverage only, with a coverage effective date of August 1, in accordance with regular effective date rules.

7.1.2 Payment for Reenrollments

For renewals of effectuated coverage, a binder payment isn't required as the renewal is a continuation of effectuated coverage, and no new effectuation is required. FFEs also do not require a binder payment for passive reenrollments that continue effectuated coverage in another plan within the same product (or to a different plan in a different product offered by the same issuer, if the current product will no longer be available to the enrollee, consistent with the hierarchy for reenrollment specified at 45 CFR §155.335(j)(2)) for the same subscriber. This means that no binder payment is required when subscribers in already effectuated policies are auto-reenrolled into coverage offered by the same issuer. Active reenrollments of effectuated subscribers only require a binder payment if the enrollee selects a plan outside the product that includes the reenrollment plan identified by the issuer in its Plan ID Crosswalk Template, consistent with 45 CFR §155.335(j). For instance, an issuer offers Products 1, 2, and 3, each with silver ("S") and gold ("G") plans. If an enrollee is enrolled in 1S, which remains available, and wants to actively select 1G during an annual Open Enrollment Period (OEP), that individual can do so without being required to make a binder payment. However, if the enrollee actively selects 2S, 2G, 3S, or 3G, a binder payment is required.

Thus, for continuing effectuated coverage, either due to renewal or certain reenrollments, as described above, issuers may continue to bill the enrollee via their existing billing cycle, and a binder payment of the first month's premium is not required by the FFEs. In such cases, non-payment of the January premium by the due date set by the issuer will trigger the applicable grace period. Where enrollees have effectuated coverage as a dependent on another subscriber's coverage, and are enrolling as subscribers into the same plan, most typically due to adult children aging off their parent's policy and enrolling into their own policies, such enrollments are new enrollments that require binder payments to effectuate.

Alternate enrollments, for QHP enrollees whose current year coverage is no longer available through the Exchange, and for whom a plan offered by a different issuer is selected, are new enrollments, not renewals, and thus require a binder payment to effectuate. Alternate enrollments are indicated by the transaction's Additional Maintenance Reason Code (AMRC) of "PASSIVE REENROLL – NEW TO ISSUER."

Payments drawn by the issuer or mistakenly provided by the enrollee for January coverage for enrollees who have selected a different issuer for coverage for the upcoming plan year, or for whom an alternative plan selection with a different issuer is made by the FFEs as part of the Batch Auto-Reenrollment (BAR) process should be promptly refunded.

7.1.3 Binder Payment Extensions Directed by the Exchange or State Authority

FFEs and State-Based Exchanges on the Federal platform will allow issuers experiencing billing or enrollment problems due to high volume or technical errors to implement a reasonable extension of the binder payment deadlines, pursuant to 45 CFR 155.400(e)(2).

If issuers comply with a state regulatory authority's request, in reaction to a natural disaster or other

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emergency disruption within a state, to extend premium payment deadlines and delay cancellations for non-payment of premium, CMS may exercise enforcement discretion with regard to regulatory requirements such as the deadline for payment to effectuate coverage and the deadline for payment of premiums under grace periods, including for individuals receiving APTC.

7.2 Premium Payment Threshold

In accordance with 45 CFR §155.400(g), QHP and Qualified Dental Plan (QDP) issuers may implement a premium payment threshold policy for their plans offered through the FFEs. QHP and QDP issuers that elect to establish such a policy generally may consider a payment to have been made in full once the enrollee pays an amount equal to or greater than the threshold amount established by the issuer, even if this is less than the total amount owed by the enrollee. Issuers who choose to implement such a policy are required by regulation to select a reasonable threshold level. We interpret a reasonable threshold to be one based on a percentage of the enrollee-responsible portion of the overall premium.³⁶ CMS recommends a percentage equal to or greater than 95%.

In accordance with the premium payment threshold regulation, QHP and QDP issuers that choose to apply a payment threshold policy must apply the policy in a uniform manner to all enrollees.

Issuers that adopt a payment threshold policy are expected to utilize such a threshold policy for the entire plan year. Additionally, if the issuer adopts such a policy, it is expected to apply the policy uniformly to the initial premium payment and/or any subsequent premium payments, and to any amount outstanding at the end of a grace period for non-payment of premium. Thus, adoption of such a premium payment threshold allows issuers flexibility to effectuate an enrollment, not to place an enrollee in a grace period for failure to pay 100 percent of the total member-responsible amount of premium due, and not to terminate enrollments after exhaustion of the applicable grace period for enrollees who have made payment(s) totaling an amount within the tolerance of the issuer's adopted threshold.

Under this type of policy, when an enrollee has paid within the premium threshold but has not paid the full enrollee-responsible portion of the premium, the enrollee still owes the balance. If the enrollee has paid the initial premium within the threshold's tolerance percentage but has not paid the full amount, the QHP or QDP issuer can still effectuate the enrollment.

If the enrollee makes subsequent premium payments within the threshold's tolerance, but has not paid the full amount due, the QHP or QDP issuer may consider the enrollee to be current on all payments due for the purpose of determining whether to place the enrollee into an applicable non-payment grace period. If the enrollee continues paying an amount less than the owed amount including past due premiums, the owed amount will accumulate and may increase beyond the threshold amount. If that is the case, the enrollee's account has become past-due and the enrollee will be subject to the grace period for failure to pay premiums.

If an enrollee fails to make payment within the threshold tolerance, he or she will be placed in the applicable grace period. If, at the end the applicable grace period, the enrollee has made payment(s) sufficient to bring their total enrollee-responsible portion of premium paid within the tolerance of the premium payment threshold adopted by the issuer, the issuer may consider the enrollee to be "in good standing" and decline to terminate for non-payment of premium. **Exhibit 19** illustrates an example of the premium payment threshold policy in action.

³⁶ The enrollee-responsible portion is equal to the total premium minus APTC.

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Exhibit 19: Premium Payment Threshold Lifecycle

Date	Action	Comments
December 10	QI selects QHP (\$100 enrollee-responsible portion after APTC)	QHP issuer has a premium payment threshold of 95%.
December 16	Enrollee billed \$100 for first month's premium	Enrollee's first month of coverage is January.
December 28	Enrollee pays \$97 for January coverage	The payment is within the threshold tolerance, so coverage is effectuated on January 1st.
January 16	Enrollee billed \$100 for February coverage, and \$3 past-due from January	The total amount billed is \$103.
February 1	Enrollee pays \$97	The issuer applies \$3 to January coverage and \$94 to February coverage. However, \$97 out of the balance due of \$103 is not within the threshold tolerance, so the issuer places the enrollee into a grace period due to the enrollee's delinquency status as of February 1. January is paid in full. February is \$6 past due.
February 16	Enrollee billed \$100 for March coverage, and \$6 past-due from February	The total amount billed is \$106. No payment is received from the enrollee.
March 16	Enrollee billed \$100 for April coverage, \$100 past-due from March, and \$6 past-due from February	The total amount billed is \$206. No payment is received from the enrollee.
April 16	Enrollee billed \$100 for May coverage, \$100 past-due from April, \$100 past-due from March, and \$6 past-due from February	The total amount billed is \$306. No payment is received from the enrollee.
April 25	Enrollee pays \$302	The issuer applies \$6 February (paid in full), \$100 to March (paid in full), and \$96 to April. Because the enrollee has paid the outstanding amount, within the applicable premium threshold amount, the grace period ends, and the enrollee exits delinquency.
April 30	Enrollee makes no additional payment	No additional payment is received by April 30. However, because the enrollee had made payments of more than 95% of the total enrollee-responsible portion of premium before the end of the grace period, the grace period was not exhausted without the enrollee paying all outstanding premiums, subject to the applicable premium payment threshold, so the issuer may not terminate the enrollee's coverage for non-payment of premium.

7.3 Terminations for Non-Payment of Premiums

In accordance with 45 CFR §155.430(b)(2)(ii) and 45 CFR §156.270, a QHP/QDP may terminate an enrollee's coverage for non-payment of premiums. Additionally, 45 CFR §156.270 requires issuers to establish and administer a standard policy for the termination of coverage for enrollees who fail to make

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full payment (or payment within the premium payment threshold if the issuer utilizes such a threshold) of their portion of the monthly premium. However, an issuer's standard policy must follow certain requirements. 45 CFR §156.270(d) requires issuers to observe a three-consecutive-month grace period before terminating coverage for those enrollees who are eligible for and have elected to receive APTC and who upon failing to timely pay their premiums, are receiving APTC. An enrollee who is eligible for APTC, but elects not to receive any APTC, is not eligible for the three-consecutive-month grace period but is eligible for the grace period the issuer normally provides to individuals who become delinquent in paying their premiums, in accordance with state rules.

In the case where an enrollee receiving APTC is enrolled in both a QHP and a QDP, if the APTC are applied and paid for both a QHP and QDP, the enrollee is eligible for the three-consecutive-month grace period for both the QHP and QDP. The enrollee is not eligible for the three-consecutive-month grace period for the QDP if the enrollee's APTC are applied and paid only for the QHP.

To avoid termination, an enrollee must pay all outstanding premiums in full, or within the tolerance of any applicable premium payment threshold, prior to the end of the applicable grace period. A grace period does not "reset" when a partial payment is made, and "rolling" grace periods, where payment of one month's premium when more than one month's premium is outstanding during the grace period would restart the three-consecutive-month grace period, are not permitted.

When an enrollee's coverage is terminated for non-payment of premiums, per 45 CFR §155.420(e), the individual does not qualify for an SEP for the resulting loss of coverage. However, if the individual becomes eligible for an SEP based on other circumstances, the individual may enroll in a QHP or QDP, including the QHP or QDP from which their coverage was terminated for non-payment. Additionally, during the annual OEP, enrollees whose coverage was terminated for non-payment of premiums before the end of the plan year will be able to apply for an eligibility determination, and, if determined eligible, will be permitted to select a QHP for coverage for the upcoming plan year. The QI is required to pay the first month's premium in accordance with 45 CFR §155.400(e) to have coverage effectuated, and the QHP or QDP must return either an 834 confirmation/effectuation or a cancellation transaction to the Exchange, as applicable. See Section 7.3.2 for information on how an issuer may condition effectuation of a new enrollment on payment of past due premium in addition to binder.

Appendix B includes an example of the content an issuer might consider in a letter providing notice of non-payment of premiums. The specific wording and messages included in Appendix B are not required but are offered as recommendations for elements in the plan's notice of non-payment when an enrollee receives APTC.

7.3.1 Examples

Example 7D: An enrollee is eligible for, but has elected not to receive, APTC. The enrollee's monthly premium is \$200, and the issuer does not make use of a premium payment threshold. The enrollee, whose coverage was effectuated for May, has not paid the June premium, which was due on June 1. The QHP issuer's standard policy, in accordance with applicable state law, is to allow a one-month grace period for enrollees not receiving APTC, but the coverage will end at the end of the month for which the last full payment is made. On June 10, the enrollee pays \$50 but does not make any further payment by the end of June. Therefore, the QHP sends an 834 termination transaction to the FFEs containing a termination effective date of May 31. The issuer should refund the \$50 premium for June in accordance with applicable state law, as no coverage was provided for June once the coverage was retroactively terminated to May 31.

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Example 7E: An enrollee receiving APTC is responsible for a \$150 monthly premium payment and the issuer does not make use of a premium payment threshold. The enrollee's coverage is effectuated, and the enrollee pays the premiums through May, but fails to make payment for the June premium, therefore entering the three-consecutive-month grace period that runs through August 31. The enrollee fails to make any payment for the July premium, and now owes the QHP issuer \$300. On July 10, the enrollee pays \$200. Since the enrollee has not paid the entire outstanding premium for which he or she is responsible, the enrollee remains in the three-consecutive-month grace period that started June 1. The enrollee fails to make any further payments, and on August 31, the QHP issuer sends an 834 termination transaction to the FFEs containing a termination effective date of June 30. The QHP issuer can keep \$150 of the \$200 payment to cover June premium, but should refund the remaining \$50 in accordance with applicable state law, as no coverage was provided for July once the coverage was retroactively terminated to June 30.

Example 7F: Circumstances are the same as Example 7E except that on July 10, the enrollee pays \$300 instead of \$200. Since the enrollee has paid the entire outstanding premium balance for which the he or she is responsible, the enrollee is no longer in the grace period. However, if the enrollee fails to make full payment for August by the payment due date, the enrollee will enter into a new three-consecutive-month grace period beginning August 1.

Example 7G: Circumstances are the same as Example 7E except that the issuer utilizes a 95% premium payment threshold. The enrollee pays no premium in June or July. The issuer bills the enrollee for August premium (\$150), which raises the total premium owed by the enrollee to \$450. The enrollee pays \$430 on August 20 and makes no further payments before August 31. Because the enrollee made a payment within the 95% tolerance of the issuer's premium payment threshold, the issuer declines to terminate for non-payment of premium at the end of the three-consecutive-month grace period. The enrollee still owes the \$20 outstanding and will enter the applicable grace period if he or she does not pay \$170 (\$150 for September premium and \$20 outstanding from the grace period), or an amount within the premium payment threshold tolerance, for September coverage.

7.3.2 Issuer Option to Condition New Enrollment on Payment of Past Due Premium

To address concerns about potential misuse of grace periods, the 2017 Market Stabilization Rule³⁷ introduced CMS's modified interpretation of the guaranteed availability rules with respect to non-payment of premiums.

Under the new interpretation, a QHP issuer would not be considered to violate the guaranteed availability requirements if the QHP issuer attributes a premium payment for coverage under the same or a different product to premiums due to the same QHP issuer within the prior 12 months and refuses to effectuate new coverage for failure to pay premiums. To the extent permitted by applicable state law, this would permit an issuer to require an individual or employer to pay all past-due premiums owed to that issuer for coverage in the 12-month period preceding the new coverage's effective date in order to effectuate new coverage from that issuer. Additionally, if the issuer is a member of a controlled group, the issuer may attribute any past-due premium amounts owed to any other issuer that is a member of such controlled group, for coverage in the 12-month period preceding the effective date of the new coverage when determining whether an individual or employer has made an initial premium payment to effectuate new coverage. For the purpose of this policy, the term "controlled group" means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal

³⁷ Patient Protection and Affordable Care Act; Market Stabilization, Final Rule, 82 Fed. Reg. 18346 (April 18, 2017)

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Revenue Code of 1986.

QHP issuers adopting this premium payment policy, as well as any QHP issuers that do not adopt the policy but are within an adopting issuer's controlled group, must clearly describe in any enrollment application materials, and in any notice that is provided regarding non-payment of premiums, in paper or electronic form, the consequences of non-payment on future enrollment, prior to the non-payment of premiums for that non-payment to be considered past-due premiums subject to this new interpretation. A QHP issuer choosing to adopt a policy of attributing payments in this way must apply its premium payment policy uniformly to all employers or individuals in similar circumstances in the applicable market regardless of health status, and consistent with applicable non-discrimination requirements. This does not permit a QHP issuer to condition the effectuation of new coverage on payment of premiums owed to a different QHP issuer (other than one in the same controlled group) or permit a QHP issuer to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person (subscriber) contractually responsible for the payment of premium. This policy applies during open enrollment and SEPs.

Because of rules regarding grace periods and termination of coverage, individuals with past-due premiums generally would owe no more than three months of premiums if existing coverage is still in a three-month APTC grace period. If prior coverage associated with an expired APTC grace period was already terminated, the enrollee seeking new coverage would only owe one month's premium. Furthermore, for individuals on whose behalf the issuer received APTC, their past-due premiums would be net of any APTC that was paid on the individual's behalf to the issuer, with respect to any months for which the individual is paying past-due premiums.

If, during an SEP or the annual OEP that occurs after termination for non-payment of premiums, a QI selects a plan offered by an issuer to which the QI does not owe any outstanding premium from the previous 12 months or which has not adopted the new interpretation of guaranteed availability, the issuer must attribute any payment from the QI toward the binder payment for the new enrollment.

7.3.3 Enrollment Transactions Received for a Subscriber Whose Coverage is Being Terminated

From time to time issuers may receive from the FFEs M834 (maintenance) transactions to update enrollments on policies that the issuer had terminated in its records, because the FFEs have not yet recorded the termination. This can occur because of timing issues in enrollment data alignment and is complicated by the retroactive termination dates of expired APTC grace periods. For example, an issuer with an enrollee who enters an APTC grace period in February that expires at the end of April can only send a non-payment termination transaction effective February 28 to the FFE after the grace period ends, in early May at the earliest. It is not uncommon for an enrollee to report life changes during the grace period months, which are sent as M834 transactions because during that time the FFE records current coverage. The FFE may continue to receive and send updates even later if the issuer delays sending the termination or the FFE doesn't immediately process it.

The analysis of whether an issuer must enroll (subject to binder) an applicant for whom it receives an M834 on a policy it has terminated or is terminating generally hinges on whether the transaction indicates a new policy issuance subject to guaranteed availability rules, which must be effectuated subject to binder; or is merely an update to a continuous original enrollment. The following rules apply on a general basis, but issuers must assess each enrollment on a case-by-case basis to ensure that they are not improperly rejecting enrollments that should be effectuated.

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Update to a Continuous Enrollment or Potential New Enrollment? An issuer must first determine whether the M834 is an update to a continuous enrollment or is a potentially new enrollment subject to binder (and the policy on attribution of payments to past due premium, if the issuer has adopted the payment policy authorized by the 2017 Market Stabilization Rule's changed interpretation of guaranteed availability). In the context of M834 transactions, the primary method of determining whether the change to the enrollment reflects a new or continuous enrollment is whether there would be a gap in coverage between the termination of the current coverage (meaning the date the APTC grace period ends, if applicable) and the effective date of the change requested by the M834 transaction. However, as noted above, this is merely a guideline, and determinations should be made on a case-by-case basis.

7.3.3.1 Examples

Example 7H: An issuer in early May terminated coverage for an enrollee receiving the benefit of APTC for nonpayment of premiums, effective February 28. Before the FFE processed the termination, the enrollee reported a life change, triggering the FFE to send an M834 transaction to the issuer with an effective date of April 1. Because April 1 is before the grace period expired, the M834 is an update to a continuous enrollment, and even if the M834 reflects that the enrollee was eligible for an SEP, the issuer should not effectuate the change to the enrollment and should maintain the February 28 termination date.

Example 7I: Same facts as above, except that the M834 transaction has an effective date of June 1. June 1 is after the expiration of the APTC grace period, so the M834 transaction is not an update to a continuous policy but rather a potentially new enrollment subject to a binder payment requirement, if additional criteria discussed below are met.

- **Is there an SEP or is it during the OEP?** An issuer must also determine whether the M834 transaction indicates eligibility for an SEP. In general, outside of Open Enrollment, a M834 transaction without an SEP on a policy the issuer has already validly terminated in its records should not be effectuated. Instead, the issuer should take the non-SEP transaction as a reminder to finish aligning its record with the FFEs by using IC834, reconciliation or Enrollment Resolution and Reconciliation (ER&R) to ensure that the FFEs record the appropriate termination date.
- M834 active transactions (policy transaction is not 11) with or without indication of an SEP during the OEP are considered new enrollments unless there would be a gap in coverage between the termination of the current coverage (meaning the date the APTC grace period ends, if applicable) and the effective date of the change requested by the M834 transaction. For example, an issuer must effectuate an enrollment under an M834 transaction, subject to a binder payment requirement (and attribution of payments to past due premium, if applicable), if it receives a non-SEP M834 with a January 1 effective date for an enrollee whose coverage was passively renewed, and who entered an APTC grace period in September that expired at the end of November (with a September 30 termination date). This is because there is a gap in coverage between the grace period end and January 1, and thus the transaction reflects a new policy issuance subject to guaranteed availability.
- As discussed above, if the M834 active transaction for an already issuer-terminated policy indicates eligibility for an SEP, then the analysis on whether to effectuate the transaction depends on whether the transaction is updating a continuous enrollment (don't effectuate) or is a new issuance (effectuate, subject to binder payment requirement and attribution of payment to past due premiums, if applicable).

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- If an issuer that has previously terminated an enrollment must later enroll the same QIs because the FFEs sent a M834 SEP transaction with an effective date after a gap in coverage between the termination of the current coverage (meaning the date the APTC grace period ends, if applicable) and the effective date of the change requested by the M834 transaction, with the QIs paying the applicable binder payment (and past due premium, if applicable) by the due date, the issuer will need to establish a gap in the FFE's policy record in enrollment data alignment. The issuer will need to use ER&R³⁸ to acquire a new FFE Policy ID for the new coverage, and may use enrollment data alignment to apply the applicable rates for the newly enrolled enrollees based on their age as of the new enrollment rather than the original start date.

Example 7J: An issuer effectuates an enrollee's coverage for January 1 in a QHP and is applying APTC. The enrollee's full premium amount is \$400, but after the application of \$300 in APTC, the enrollee's member-responsible portion of premium is \$100. The enrollee makes all payments fully until he or she fails to pay the July premium, due July 1. The enrollee enters into the three-consecutive-month grace period on July 1, and the grace period expires September 30. On July 15, the enrollee loses the benefit of APTC (effective on August 1), due to the expiration of a data matching inconsistency (DMI) period. After receiving a bill for August coverage (\$400), which reflects the change in APTC, the enrollee returns to the FFE on August 10, is determined newly eligible for APTC (effective on September 1), and utilizes the SEP under 45 CFR 155.420(d)(6) to maintain enrollment in the same plan. The enrollee pays the QHP issuer \$100 on August 15 but makes no further premium payment. The enrollee's coverage is terminated by the QHP after the APTC grace period expires, with a termination effective date of July 31. Since the Financial Change SEP M834 transaction restarting APTC for the enrollee effective September 1 updated the original coverage effective date during the applicable grace period without a gap between the current coverage and the effectiveness of the change, the M834 transaction effective September 1 is considered to be part of one continuous enrollment, extending from January 1 through July 31, rather than one enrollment starting on January 1 through July 31 and a second, new enrollment starting on September 1 (there was no gap in coverage before the September 1 effective date of the M834 transaction because the policy was still in the grace period on September 1). Therefore, the QHP issuer must terminate the enrollee's coverage on July 31 for non-payment of premium.

Example 7K: Same facts as above, but here the enrollee is determined eligible for an SEP on August 10 but does not utilize the SEP until October 1. On that date, the former enrollee selects the same QHP under which the former enrollee's coverage was terminated effective July 31 and is provided an effective date of November 1. The former enrollee makes a timely and sufficient binder payment. If the QHP issuer has not adopted the new interpretation of guaranteed availability (or is not part of a controlled group that has adopted the new policy interpretation), the QHP issuer must effectuate the new coverage because a gap in coverage (from September 30, when the grace period ended, through October 31) exists. For examples of how the new interpretation of guaranteed availability would change this outcome for issuers who have adopted it, please see the examples below.

Example 7L: Same facts as above, but here the enrollee is determined newly eligible for APTC (Financial Change SEP) on August 10 and utilizes the SEP to enroll in a plan in a different product, but with the same issuer (this is sent TERMCIC rather than M834 because the QHP ID has changed). The active selection of a QHP in a different product makes this a new issuance subject to a binder payment requirement. The enrollee makes a timely and sufficient binder payment on August 25. If the QHP issuer

³⁸ For information on requesting a new FFE Policy ID because a coverage gap has been established in a previous continuous segment, see slides 14–20 at https://zone.cms.gov/system/files/documents/issuer_technical_slides_2017_05_09_v05.pdf.

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has not adopted the new of interpretation of guaranteed availability (or is not part of a controlled group that has adopted the new policy interpretation), the QHP issuer must effectuate the new coverage because the enrollee actively selected a plan in a new product, which is not considered by the FFE to be a continuous enrollment and thus the issuer must collect a binder payment to effectuate the enrollment. For examples of how the new interpretation of guaranteed availability would change this outcome for issuers who have adopted it, please see examples 7O through 7S below.

7.3.4 Additional Non-Payment Examples

Example 7M: An issuer effectuates a QI's enrollment with an effective date of January 1. On May 15, the QHP issuer notifies all of its current enrollees about its implementation of the new interpretation of guaranteed availability and how that policy will affect enrollees whose coverage is terminated for non-payment of premium. The QI fully and timely pays the member-responsible portion of premium (here, \$100 per month) for all months of coverage until July. The enrollee, who is receiving the benefit of APTC, enters a three-consecutive-month grace period on July 1. The enrollee does not make any premium payments during the grace period, and the QHP issuer terminates their coverage, effective July 31, with \$100 in uncollected past due premium. On October 1, the individual utilizes an SEP to reenroll in coverage with the same QHP issuer. The member-responsible portion of premium for the new coverage, which would have an effective date of November 1, is \$100. The individual timely pays the QHP issuer the \$100 binder payment. The QHP issuer may decline to effectuate the new enrollment because the individual must timely pay \$200, or an amount sufficient to satisfy any applicable premium payment threshold, consistent with 45 CFR 155.400(g), comprising the premium owed for July coverage and the binder payment for November coverage, in order to effectuate new coverage with the QHP issuer. The QHP issuer may retain the \$100 paid for new coverage to offset premiums owed from the individual's coverage terminated on July 31.

Example 7N: The same facts as above, but here the QI timely pays the QHP issuer \$200 for the coverage beginning on November 1. The QHP issuer must effectuate the new coverage in accordance with all applicable rules.

Example 7O: The same facts as above, but here the QI utilizes their SEP to enroll in coverage with a new QHP issuer that is not part of the controlled group of the QHP issuer that terminated their coverage effective July 31. If the QI timely pays the binder payment, or an amount sufficient to satisfy any applicable premium payment threshold, consistent with 45 CFR 155.400(g), the enrollee's new coverage will begin effective November 1. The new QHP issuer may not refuse to offer coverage due to premiums owed stemming from the enrollee's previous coverage (and indeed would likely be unaware of the other debt).

Example 7P: An issuer effectuates a QI's enrollment with an effective date of January 1. The member-responsible portion of premium for the coverage is \$100. The enrollee fully and timely pays the member-responsible portion of premium for all months from February through June but does not make any premium payment for July coverage. The enrollee, who is receiving the benefit of APTC, enters a three-consecutive-month grace period on July 1. The enrollee does not make any premium payments during the grace period and the QHP issuer terminates their coverage, effective July 31, but had not notified the enrollee of the consequences of non-payment consequent to the QHP issuer's adoption of the new interpretation of guaranteed availability. On October 1, the enrollee utilizes an SEP to reenroll in coverage with the same QHP issuer. The member-responsible portion of premium for the new coverage, which would have an effective date of October 1, is \$100. The enrollee timely pays the QHP issuer the \$100

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binder payment. Although the QHP issuer has implemented the new interpretation of guaranteed availability, it may not attribute the \$100 binder payment to the \$100 past-due premium from the prior coverage and reject the enrollee's new enrollment based on failure to make a binder payment, because it did not provide notice to the enrollee of the consequences of non-payment of premium. The QHP issuer must accept the payment and effectuate the enrollment and may only apply payments received toward past due premiums accrued after the enrollee was properly noticed, via written or electronic notification, of the consequence of non-payment.

Example 7Q: An issuer effectuates a QI's enrollment with an effective date of January 1. Subsequent premiums are due the day before the coverage month. The QHP A issuer, and all issuers in the same controlled group as that issuer, properly notify the enrollee of the issuer's adoption of CMS's new interpretation of guaranteed availability and the consequences of non-payment of premium. The enrollee fully and timely pays the \$100 member-responsible portion of premium for the months of February and March but does not make any subsequent premium payment for the enrollment in QHP A issuer. The enrollee, who is receiving the benefit of APTC, enters a three-consecutive-month grace period on April 1. On June 1, the enrollee utilizes an SEP to enroll in new coverage in QHP B, with a coverage effective date of July 1. The QHP B issuer is in the same controlled group as the QHP A issuer. The member-responsible portion of premium for QHP B is \$100 and the binder payment deadline is July 1. On June 15, the enrollee, who has not made any premium payments to the QHP A issuer for April, May, or June, pays the QHP B issuer \$100 for the binder payment for new coverage. The QHP B issuer may attribute the \$400 to the past due premiums owed to the QHP A issuer and decline to effectuate the new enrollment because the enrollee, in order to effectuate coverage, must timely pay the applicable past due premiums owed to the QHP A issuer, or an amount sufficient to satisfy any applicable premium payment threshold, consistent with 45 CFR 155.400(g), and the binder payment for QHP B July coverage. If, before the expiration of the grace period, the enrollee does not make sufficient further payments to satisfy premium owed for coverage under QHP A, the QHP A issuer must terminate the enrollee's coverage effective April 30, and the QHP A/QHP B controlled group may retain the \$100 paid for QHP B coverage to offset premiums owed for the enrollee's April coverage under QHP A.

Example 7R: Same facts as above, but here the enrollee timely pays the binder payment for QHP B coverage and \$100 for April QHP A coverage on July 1. Because the QHP A issuer terminated coverage on June 30, effective retroactively to the end of April, and only the premium for April would be considered past-due premium, the QHP B issuer must accept the binder payment and effectuate the new coverage in accordance with all applicable rules.

Example 7S: An issuer effectuates a QI's enrollment with an effective date of January 1. The QHP issuer properly notifies the enrollee of its adoption of CMS's new interpretation of guaranteed availability and the consequences of non-payment of premium. The enrollee fully and timely pays the member-responsible portion of premium for the months of February and March but does not make any premium payment for April coverage. On April 1, the enrollee, who is not receiving the benefit of APTC, enters a grace period governed by state rules, the length of which is one calendar month with a termination date of the last date of good standing. The enrollee does not make sufficient payment to satisfy the outstanding premium and the QHP issuer terminates the enrollment with an effective date of March 31. On June 1, the enrollee utilizes an SEP to enroll in new coverage with the same QHP issuer, with a coverage effective date of July 1. The member-responsible portion of premium for QHP B is \$100. The enrollee timely pays the QHP issuer \$100 for the binder payment for new coverage. The QHP issuer must accept the binder payment

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and effectuate the enrollment because the enrollee does not owe any premium from their previously terminated enrollment.

Example 7T: An issuer effectuates a family's enrollment for January 1. On May 15, the QHP issuer notifies all of its current enrollees about its implementation of the new interpretation of guaranteed availability and how that policy will affect enrollees whose coverage is terminated for non-payment of premium. The subscriber for the family's policy fully and timely pays the member-responsible portion of premium (here, \$100 per month) for all months of coverage until July. The enrollment, for which APTC is being paid, enters a three-consecutive-month grace period on July 1. The subscriber does not make any premium payments during the grace period and the QHP issuer terminates the coverage, effective July 31, with \$100 in uncollected past due premium. On October 1, the family (with the same subscriber as the enrollment that was terminated on July 31) utilizes an SEP to reenroll in coverage with the same QHP issuer. The member-responsible portion of premium for the new coverage, which would have an effective date of November 1, is \$100. The subscriber timely pays the QHP issuer the \$100 binder payment. The QHP issuer may allocate the \$100 binder payment to the past due premiums and decline to effectuate the new enrollment because the subscriber must timely pay \$200, or an amount sufficient to satisfy any applicable premium payment threshold, consistent with 45 CFR 155.400(g), comprising the premium owed for July coverage and the binder payment for November coverage, in order to effectuate new coverage with the QHP issuer. The QHP issuer may retain the \$100 paid for new coverage to offset premiums owed from the coverage terminated on July 31.

Example 7U: Same facts as above, but here the subscriber for the SEP enrollment for October 1 is not the subscriber for the enrollment terminated on July 31. If the new subscriber timely pays the \$100 binder for coverage for November, the QHP issuer may not decline to effectuate the new enrollment due to the outstanding debt owed by the previous subscriber. The QHP issuer must effectuate the coverage under the applicable coverage effective date rules. If, during a grace period for non-payment of premium, an enrollee loses eligibility for APTC but regains APTC, the transaction will be handled through an M834 and the QHP issuer may treat the enrollment as being continuous. Thus, unless the enrollee's coverage is terminated for non-payment of premium, the issuer may attribute the enrollee's forthcoming premium payments to the outstanding debt associated with the current enrollment. If the enrollee's coverage is terminated for non-payment of premium, any new coverage with the same issuer would fall under the modified guaranteed availability requirements, described above, with respect to non-payment of premiums.

7.4 Grace Periods for Enrollees Receiving the Benefit of APTC

The regulation at 45 CFR §156.270(d) requires issuers to provide a grace period of three consecutive months for an enrollee, who when failing to timely pay premiums, is receiving the benefit of APTC. During the grace period, the QHP issuer must 1) pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; 2) notify HHS of such non-payment;³⁹ and 3) notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

³⁹ Issuers notify HHS of nonpayment through the Enrollment Data Alignment process.

7.4.1 Claims Pended by an Issuer During a Three-Consecutive-Month Grace Period for Enrollees Receiving the Benefit of APTC

Under 45 CFR §156.270(d)(1), issuers may pend claims for services rendered, if permitted by state law, for enrollees receiving the benefit of APTC who are within the second or third months of the three-consecutive-month grace period. If the enrollee is enrolled in both a QHP and a QDP, is receiving APTC for both plans, and is in the second or third months of the three-consecutive-month grace period for both forms of coverage, both the QHP and QDP issuers may pend claims, if permitted by state law. If the issuer terminates the enrollee's coverage for non-payment of premiums retroactively to the last day of the first month of grace, the issuer may deny any claims that were pended for services received during the second and third months of the three-consecutive-month grace period. However, the issuer cannot retroactively deny claims from the first month of the three-consecutive-month grace period based on the termination of coverage. Any premium collected by the issuer for coverage beyond the designated retroactive termination date should be refunded to the enrollee whose coverage was terminated, in accordance with applicable state law.

In accordance with 45 CFR §156.270(d)(3), QHP and QDP issuers must notify providers of the possibility of denied claims for services incurred during months two and three of the three-consecutive-month grace period for enrollees receiving APTC. CMS expects issuers will provide this notice within the first month of the grace period and throughout months two and three. Issuers can opt to provide this notice by several means; however, issuers are encouraged to provide this notice whenever responding to an eligibility verification request from a health or dental care provider.

7.4.2 Grace Periods Ending After the End of the Annual Open Enrollment Period

The grace period for non-payment of premiums could extend past the end of the annual OEP if enrollees who are receiving the benefit of APTC fail to timely pay their premium in full or in an amount necessary to satisfy a payment threshold, if applicable, for October, November or December coverage.

If the enrollees' coverage is still in effect at the time of auto-renewal (typically October), and the enrollees have not taken action to actively select a QHP for future year coverage, the FFEs generally automatically send the 834 renewal transaction to the enrollees' QHPs. If the FFEs send an auto-reenrollment transaction (even if the reenrollment plan is offered under a different product), or if enrollees actively complete a plan selection to renew enrollment through the Exchange in a plan offered under the same product as their reenrollment plan (where the product under which the QHP in which he or she is enrolled is not available through the individual market Exchange for renewal, this includes a plan under a different product offered by the same QHP issuer, to the extent permitted by applicable state law),⁴⁰ the QHP issuer must accept the enrollment, because enrollees are still in a grace period, meaning that the issuer may not discontinue enrollees' coverage based on failure to pay their premiums. However, if a QHP issuer has adopted the new interpretation of guaranteed availability contained in the 2017 Market Stabilization Rule,

⁴⁰ Pursuant to the Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, 79 FR 52994 (September 5, 2014), when a product that included QHPs no longer offers QHPs through a Marketplace (for example, if the issuer does not apply for recertification of any plans within the product, but continues to offer the product in the market), and enrollees in that product are reenrolled in a QHP under a different product pursuant to 45 CFR §155.335(j)(2), that reenrollment would be considered a renewal, consistent with 45 CFR §147.106, and would be considered a renewal for purposes of determining whether the issuer could attribute any payment from the individual toward any outstanding debt that may exist between the individual and that issuer and then refuse to enroll the applicant or terminate the applicant's enrollment based on failure to pay premiums.

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the issuer would not be considered to violate the guaranteed availability requirements if the QHP issuer attributes a premium payment for coverage under the same or a different product to premiums due to the same QHP issuer (or a different issuer in the same controlled group of issuers) within the prior 12 months and refuses to effectuate new coverage for failure to pay premiums, provided adequate notice of the policy is provided. For both auto-renewals and active plan selections that are continuations of the same coverage, as previously described in Section 7.3.2, the issuer may attribute enrollee payments to the oldest outstanding debt in the existing grace period for the current coverage.

However, consistent with 45 CFR §156.270 and §155.430, if the enrollee does not pay all outstanding premiums, or an amount within the tolerance of any applicable premium payment threshold, by the end of the three-consecutive-month grace period, the issuer must terminate the enrollee's coverage retroactively to the last day of the first month of the grace period. If the coverage in the new plan year resulted from a renewal of the terminated coverage and is considered a continuation of the current coverage, renewal coverage that is still in passive status (enrollments sent through auto-reenrollment that still have a policy status of 11) will be cancelled by the FFEs (typically within a month of receiving the prior year termination from the issuer) because nonpayment of premium is an exception to guaranteed renewal; the enrollee will be unable to enroll in coverage for the new plan year outside the OEP unless the enrollee is eligible for an SEP. Active enrollments during OEP that result in coverage that is not considered a continuation of the same coverage are governed by guaranteed availability rules, and so some active reenrollments that would otherwise be cancelled if they were passive reenrollments must be effectuated by the issuer, subject to payment of the required binder payment (and past due premium, if applicable).

7.4.2.1 Examples

Example 7V: An enrollee receiving the benefit of APTC entered a grace period in September and did not pay all outstanding premium due by November 30, and coverage is terminated effective September 30. During the OEP the enrollee actively selects the same renewal plan effective January 1, which the issuer receives as an M834 transaction because the active reenrollment is an update to the auto-reenrollment sent to the issuer in October. The issuer must accept the January 1 enrollment subject to the requirement to pay a binder payment (and past due premium, if applicable).

Example 7W: Similar facts as above except that the enrollee entered the APTC grace period in November and did not pay all outstanding premium by January 31, and thus the coverage is terminated November 30 by the issuer for nonpayment of premiums. During the OEP, the enrollee actively selects the renewal plan effective January 1. While the FFEs will not automatically cancel the enrollment because it is in active (not passive) status, the issuer may send a separate cancel transaction for the January 1 coverage because the renewal was an update to a continuous enrollment being terminated (January 1 is not more than one day later than the grace period end of January 31).

Example 7X: An enrollee, who receives APTC, is enrolled in a QHP. The QHP issuer does not utilize a premium payment threshold policy. The enrollee has paid premiums in full throughout the year but fails to pay the December premium by the December 1 due date and enters a three-consecutive-month grace period that would end on the last day of February. The enrollee does not actively select a plan for the new plan year, and the FFEs send an auto-renewal transaction. The QHP issuer must accept the enrollment. The renewed coverage continues into the new plan year, subject to the existing grace period. The enrollee does not pay all outstanding premiums by February, and the QHP issuer retroactively terminates the enrollee's coverage, effective December 31 of the prior year. The individual is no longer covered for the

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new plan year, which the FFEs' record will reflect once the Exchange has cancelled the auto-renewal. Since the annual OEP has ended, the individual cannot enroll through the Exchange until the next annual OEP, unless the individual qualifies for an SEP.

Example 7Y: Same facts as above, except the enrollee fails to pay the November premium by the November 1 due date and enters a three-consecutive-month grace period that would end on the last day of January. During the OEP, on December 4, the enrollee logs into HealthCare.gov, updates their application for the upcoming plan year, and is determined eligible for coverage. The enrollee actively renews the same coverage for January 1 and pays the first month's premium by the due date. Because the enrollee decided to renew their coverage in the same product, which is considered a renewal, the QHP may apply the January premium payment to the November non-payment. Because the enrollee is still within the three-consecutive-month grace period, the issuer may not refuse to renew the enrollment. However, if the enrollee does not pay all outstanding premiums by January 31, the QHP must retroactively terminate the enrollee's coverage, effective November 30. The enrollee would no longer be covered for the new plan year and the QHP issuer must send the FFEs a termination transaction for the prior year plan, effective November 30. The FFEs will cancel the new plan year auto-renewal within weeks if it is still in passive status, or alternatively, the issuer may send a cancellation transaction for the enrollment.

7.4.3 Grace Periods Ending on or Before December 31

When an enrollee with a grace period expiring on or before December 31 actively reselects coverage offered by the same issuer during an OEP with a January 1 effective date, the issuer will generally need to treat the active reenrollment under guaranteed availability rules, effectuating the new coverage, subject to the requirement to pay a binder payment (and any past due premium, if the issuer has adopted the new payment policy). This is because the new coverage's start date is after the end of the grace period for the previous coverage, making it a new issuance rather than an update to a terminated policy that can be disregarded. Reenrollments still in passive status (policy origin = 11), however, may be cancelled, since eligibility for auto-renewal ends if the associated prior year enrollment subsequently terminates.

7.4.3.1 Examples

Example 7Z: An enrollee who has been properly notified that her issuer will condition new enrollment on collection of past due premium accrued within the previous 12 months enters APTC grace in September for failing to pay the \$50 premium. The FFEs send the issuer an auto-renewal in October, which the issuer must process as the enrollee's coverage is still in grace. The enrollee makes no more payment on the current year coverage by the November 30 end of the grace period, so the issuer sends the FFEs a termination effective September 30 in early December on the current year coverage. However, on November 15, the enrollee actively reenrolled in coverage offered by the issuer under the same product, indicated on a M834 transaction updating the auto-reenrollment, making it an active reenrollment (policy origin \neq 11) subject to guaranteed availability requirements.

The binder on the new coverage is \$100. The enrollee pays the issuer \$150 by the new coverage binder due date, which the issuer has set as January 1. The issuer must effectuate the coverage, as the enrollee has paid binder and applicable past due premium.

Example 7AA: Same facts as above, except the enrollee never actively reenrolls, leaving the reenrollment in passive (policy origin = 11) status. The issuer terminates the current year policy effective September 30 and may cancel the passive reenrollment or wait for the FFEs to carry the current year termination

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forward to cancel the future year enrollment.

7.4.4 Termination Occurring During a Grace Period

45 CFR §155.430 allows an enrollee to voluntarily terminate their coverage by notifying the Exchange. If an enrollee seeks to voluntarily terminate coverage while he or she is in a grace period due to non-payment of premiums, the effective date of termination is the earlier of: 1) the enrollee's voluntary termination date, or 2) the date the enrollee's coverage is terminated for non-payment of premiums (involuntary termination date) if the enrollee fails to pay all outstanding premiums, or an amount within the tolerance of any applicable premium payment threshold, before the end of the applicable grace period.

7.4.4.1 Examples

Example 7BB: An enrollee, who is enrolled in a QHP with an issuer that does not utilize a premium payment threshold, is receiving APTC and enters a grace period on August 1, due to their non-payment of premiums. The grace period extends until October 31, and if the enrollee does not pay their outstanding premiums in full by that date, their coverage will terminate effective August 31, the last day of the first month of the grace period for enrollees receiving APTC. In September, the enrollee contacts the FFEs to voluntarily terminate their coverage September 30 because the enrollee will enroll in employer coverage effective October 1. The FFEs send an 834 transaction to the issuer with a termination effective date of September 30. The enrollee makes no further payments to the issuer. By the end of their grace period (October 31), he or she has not paid all outstanding premiums to the issuer. On November 1, the issuer uses enrollment data alignment to change the enrollee's effective date of termination to the date of involuntary termination for non-payment of premiums, August 31. The issuer can reject any claims arising from medical service provided after August 31 and must return any APTC paid on the enrollee's behalf for the period after August 31 in accordance with applicable state law.

Example 7CC: An enrollee, who does not receive APTC, enters a grace period for non-payment of premium on August 1. The law in the enrollee's state allows a one-month grace period to pay all outstanding premiums. If the enrollee does not pay all outstanding premiums, or an amount within the tolerance of any applicable premium payment threshold, during that one-month grace period, the issuer may terminate their coverage effective July 31, the last day the enrollee's account was in good standing. In August, the enrollee accesses the FFEs to voluntarily terminate their coverage, effective August 24 and the FFEs send an 834 transaction to the issuer with a termination date of August 24. On the last day the enrollee's grace period, August 31, he or she has not paid the outstanding premium owed to the issuer. On September 1, the issuer uses reconciliation to change the enrollee's termination date to July 31.

7.4.5 Involuntary Termination Due to a Citizenship/Immigration Status Inconsistency Expiration During a Grace Period

An enrollee who receives coverage during a citizenship/immigration status inconsistency period, and who does not pay monthly premiums timely, will enter the applicable grace period pursuant to 45 CFR §155.430 and 45 CFR §156.270. If the inconsistency expires during the grace period, the enrollee's Exchange coverage or enrollment termination date will be the earlier of: 1) the date of the inconsistency expiration, or 2) the termination date associated with the applicable grace period. Note that lack of lawful presence is not an exception to guaranteed renewal, and the terminated enrollee may be eligible to continue coverage outside the Exchange.

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7.4.5.1 Examples

Example 7DD: An enrollee, who receives APTC, is in a citizenship/immigration status inconsistency period that expires June 30, unless it is resolved earlier. The enrollee is also in a grace period ending on June 30, because he or she did not pay their April premium in full. As of June 30, the enrollee's inconsistency has not been resolved. Additionally, as of June 30, the enrollee has not paid the outstanding premium, and their coverage terminates effective April 30, per 45 CFR §155.430 and 45 CFR §156.270. The termination for non-payment retroactive to April 30 applies.

7.4.6 Termination of APTC During a Grace Period

If an enrollee receives the benefit of APTC and is delinquent on premium payments, the enrollee will receive a three-consecutive-month grace period, pursuant to 45 CFR §156.270(d). If such an enrollee becomes ineligible for the benefit of APTC during the three-consecutive-month grace period, the APTC will terminate according to normal Exchange operations, but the enrollee will have until the end of the three-consecutive-month grace period to pay all outstanding premium, or an amount within the tolerance of any applicable premium payment threshold. If the enrollee does not make sufficient payment to avoid termination for non-payment, the enrollee's termination date would adhere to the rules for an APTC grace period stated in 45 CFR §155.430(d)(4).

7.4.6.1 Examples

Example 7EE: An enrollee, who is receiving the benefit of APTC and is subject to an annual household income inconsistency, enters a grace period on August 1, due to their non-payment of premium. The grace period extends until October 31. On August 31, the enrollee's income inconsistency expires and the APTC are adjusted to \$0 by the FFEs. Although the FFEs will end the enrollee's APTC effective September 1, the enrollee will have until October 31 to make full payment of all outstanding premium to avoid their coverage being terminated effective August 31, the last day of the first month of the grace period.

7.4.7 Premium Paid to an Issuer Through a Third-Party

Any contract between an issuer and a third-party under which the third-party collects premium payments from enrollees and routes them to issuers is governed by applicable state law. When the third-party payment vendor charges fees for its service, such as processing fees, in addition to the premium amount collected, issuers may not consider such fees to be part of the premium, and may not consider an enrollee's failure to pay the fees to be a non-payment of premium.

Accordingly, if an enrollee's premium payment is routed to the issuer, the issuer cannot trigger applicable grace periods or terminate the enrollee's coverage for non-payment of fees. Rather, relationships between issuers and third-parties should be designed much like relationships in other commercial arenas where individual may make in-person payments to vendors who will deliver their payment to a utility or other creditor and require the individual to pay any processing or transaction fee directly to the third-party before the third-party transmits the payment to the ultimate recipient. CMS encourages issuers to require that processing fees be delineated separately from the premium payment on any receipt or other evidence of the transaction.

7.5 Over-Billed Premiums

QHP and QDP issuers may correct any over-billed premium amount, which is when an issuer bills an enrollee or enrollees for an erroneously high premium amount, according to their own policies and consistent with applicable state law. Issuers should, within a reasonable time of the discovery of the over-billing, credit the over-billed premium to the enrollees' accounts, refund the over-billed amount to the enrollees, or use a combination of both solutions.

QHP and QDP issuers must reduce the APTC amount in their systems if the total amount of APTC applied to an enrollee's account exceeds total plan premium. Any resulting APTC discrepancies would be addressed during enrollment reconciliation.

7.6 Under-Billed Premiums

The term "under-billed premium" refers to a circumstance where an issuer bills an enrollee an erroneously low premium amount (or does not bill the enrollee at all). Issuers of QHPs in FFEs, as well as issuers in states where CMS directly enforces the Patient Protection and Affordable Care Act (PPACA) market reforms that discover an under-billing error should consult CMS by informing their CMS Account Manager. In a state where CMS directly enforces the PPACA market reforms, in collaboration with the appropriate state regulator, CMS will consider exercising enforcement discretion to allow issuers to forego collection of under-billed premium on a case-by-case basis. In a state that has retained primary enforcement authority of the PPACA market reforms, CMS generally defers to the relevant state authority. Therefore, the relevant state authority may direct or permit an issuer to forego the collection of any under-billed portions of premiums. Such action alone does not constitute a failure to substantially enforce premium-related requirements, as long as state policies are applied consistently and in a non-discriminatory fashion. Should any issuer forego collection of any under-billed premium, either under an exercise of CMS enforcement discretion or at the direction of the applicable state authority, the issuer must characterize the uncollected premiums as realized/earned premium for purposes of medical loss ratio (MLR) and risk adjustment (RA) data submission.

7.6.1 Examples

Example 7FF: On December 5, Enrollee A completes an application for enrollment through the FFE, makes a plan selection, and enrolls in a QHP with an effective date of January 1. Enrollee A pays their first month's premium on time, and the enrollee's coverage is effectuated for January 1. Enrollee B (who lives in the same state as Enrollee A) completes an application for enrollment through the same FFE, makes a plan selection, and enrolls in the same QHP as Enrollee A with an effective date of January 1. Enrollee B pays their first month's premium on time, and the enrollee's coverage is effectuated for January 1. The issuer bills Enrollee A and Enrollee B for premiums in February and March. Enrollee A and Enrollee B pay in full. While generating the April billing invoices, the issuer's billing system malfunctions, causing the issuer to bill Enrollee A for April's premium while failing to bill Enrollee B. Enrollee A pays their premium for April coverage, but Enrollee B does not, since he or she did not receive a bill. The next month, the same malfunction occurs; Enrollee A pays the May premium and Enrollee B does not. The issuer realizes the billing problem while generating invoices for June. Both Enrollee A and Enrollee B reside in State Z, which has retained primary enforcement authority. The State Z Department of Insurance instructs the issuer to forego collection of Enrollee B's under-billed premium. As long as this policy is applied consistently and in a non-discriminatory manner, the issuer can forego collection of the under-billed premium related to Enrollee B's account, but it must report such uncollected premium to

CMS as being earned/realized income for purposes of MLR and RA.

7.6.2 Collections and Grace Periods for Non-Payment of Under-Billed Premium

When an issuer identifies an amount of premium that has been under-billed, and attempts to collect such amounts, issuers are highly encouraged to allow affected enrollees a reasonable amount of time in which to pay such premium amounts, and should take steps to ensure that the time for repayment is adequate in light of the enrollee's regularly-billed monthly premium amounts. QHP and QDP issuers are permitted to allow enrollees to pay under-billed premium in equal installments, in accordance with applicable state law. If a QHP or QDP issuer chooses to allow an enrollee to pay under-billed premium in equal installments, the issuer should provide the enrollee with documentation that clearly defines the amount of under-billed premium that the issuer will add to the regularly-billed monthly premium, as well as guidance informing the enrollee that if he or she does not pay all under-billed premium installments (as well as all regularly-billed monthly premiums) by the prescribed due dates, he or she will enter the applicable grace period. Issuers are expected to maintain evidence of this payment plan for under-billed premiums for 10 years (45 CFR §156.705). CMS expects issuers to maintain applicable documentation of the state's decision, and SOPs demonstrating that payment plans were applied uniformly.

The non-payment of under-billed premium amounts due is treated the same as the non-payment of regular monthly premium amounts with regard to grace periods and premium payment thresholds. Therefore, if an enrollee fails to pay any outstanding under-billed premiums to the QHP or QDP issuer by the date such amounts are due, he or she enters into the applicable grace period specified by 45 CFR §155.430 and 45 CFR §156.270. Upon triggering the grace period, the entire amount of outstanding under-billed premium can become due, if permitted by state law.

7.6.2.1 Examples

Example 7GG: Enrollee A lives in State Y, which has retained primary enforcement authority of the PPACA market reforms. On December 5, Enrollee A completes an application for enrollment through the FFE, makes a plan selection, and enrolls and effectuates coverage in a QHP with an effective date of January 1 and a premium of \$400. The enrollee is eligible for, and elects to receive the benefit of, APTC, applying \$300 APTC to premium, leaving her responsible for \$100/month. The issuer's premium due date is the first of each month. Enrollee A reports a change in income that makes her ineligible to receive APTC beginning in April. While generating the April premium bill, the issuer's billing system malfunctions, causing the issuer to fail to correct Enrollee A's bill to reflect the full premium due, without APTC. The same malfunction occurs during the generation of the May and June premium invoices, meaning the enrollee was under-billed \$900 (\$300 each for April, May, and June). The issuer discovers the under-billing error in time to correct the July bill and properly informs its applicable state authority and consults CMS by contacting its CMS Account Manager.

State Y directs the issuer to recoup the enrollee's under-billed premiums, starting with the April payment. The issuer allows the enrollee six months to repay the under-billed premiums, billing the enrollee an extra \$150 for July – December, meaning she must pay \$550 each month to maintain good standing (\$400 regular premium, plus \$150 under-billed premium installment). Enrollee A pays only \$400 of her \$550 July premium, and thus becomes delinquent. Because she is no longer receiving APTC, her grace period is determined by State Y, which has a one-month grace period that begins on July 1, the date she entered delinquency. If she fails to pay all her premium due (within the payment threshold, if applicable) by July 31, the issuer must terminate her coverage due to non-payment back to June 30, the last day of good standing pursuant to State Y's grace period policy, which is the last day of the month before her grace

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period started.

Example 7HH: Same facts as above, except the enrollee is not eligible for APTC as of July 1. Without APTC, the enrollee's monthly premium is \$200. The enrollee pays \$280 for July coverage but pays only \$200 for August coverage. Pursuant to State X's rules, because the enrollee underpaid by \$80 for August, he or she enters into a one-month grace period and termination of their coverage for non-payment of premiums would be retroactive to the last day their account was in good standing (July 31 in this example). To avoid termination of their coverage, the enrollee must pay the entire outstanding amount of under-billed premium (\$320) before the end of State X's grace period. The enrollee pays the issuer \$320 on August 28, and the issuer begins normal monthly premium billing for September.

Example 7II: On December 5, an enrollee completes an application for enrollment through the FFE, makes a plan selection, and enrolls in a QHP, whose issuer does not utilize a premium payment threshold, with an effective date of January 1. The enrollee is eligible for, and elects to receive the benefit of, APTC, and their portion of the monthly premium for which he or she is responsible is \$100. The enrollee pays the first month's premium, and coverage is effectuated for January 1. The issuer bills the enrollee normally for coverage in February. The enrollee pays their \$100 monthly premium in full. While generating the invoices for March, the issuer realizes that the enrollee's premium has been rated incorrectly and that the proper monthly premium is \$120. The enrollee's new premium goes into effect with QHP A's March billing cycle. The enrollee resides in State Y, which directs the issuer to recoup the under-billed premium. The issuer informs the enrollee of the discrepancy and, beginning with the March billing, allows the enrollee to pay two monthly installments of \$20 in addition to the corrected premium payments of \$120 to pay the under-billed premium and bring the account into good standing.

While the enrollee may be eligible for an SEP based on the error, he or she decides to remain enrolled in the same QHP. The enrollee sends the issuer \$120 for March coverage but does not include a \$20 under-billed premium installment. Although the enrollee paid the new regular monthly premium for March (\$120), the enrollee did not pay the first under-billed premium installment. He or she enters into a three-consecutive-month grace period on March 1 and must pay all additional regular monthly premium billed during the grace period (\$120 for April and \$120 for May), and the outstanding under-billed premium amount (\$40) by the expiration of the grace period to avoid termination for non-payment of premium. During the grace period, the enrollee pays the issuer a total of \$240. At the end of the three-consecutive-month grace period, the enrollee still owes the issuer \$40, since although he or she made sufficient payments to satisfy all regular monthly premiums billed during the grace period (\$360), the enrollee did not remit the under-billed premium amount (\$40). The issuer terminates the enrollee's coverage, retroactive to the last day of the first month of the grace period (March 31), for non-payment of premiums. The issuer will receive the enrollee's APTC for March, and it may retain the premium the enrollee paid for March, but it must return the APTC paid on their behalf for April and May, and refund the enrollee the premium he or she paid for April and May (\$240).

Example 7JJ: Same facts as Example 7II, except the enrollee is not eligible for APTC as of March 1. Here, the enrollee's monthly premium is \$200. If the enrollee pays only \$200 for May coverage, failing to include \$20 for the under-billed premium installment, the enrollee enters a one-month grace period, starting on March 1, as determined by the rules of the enrollee's state. He or she must pay the amount of outstanding under-billed premium (\$40) before the expiration of the grace period to avoid termination of their coverage. During the grace period, the enrollee makes no further payments. Although the enrollee paid the regular monthly premium of \$200 for March, the enrollee failed to pay the under-billed premium in full by the expiration of the grace period. As a result, the issuer may terminate their coverage,

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retroactive to February 28, the last date that the enrollee was in good standing.

7.6.3 Voluntary Termination of Coverage During Repayment of Under-Billed Premium

If an enrollee voluntarily terminates their coverage during the time he or she is paying under-billed premium installment payments, the enrollee's current QHP and/or QDP issuer can, if permitted by state law, accelerate payment by converting remaining installments, if any, into a lump sum payment due no earlier than the date the voluntary termination will take effect.

7.6.3.1 Examples

Example 7KK: On December 5, an enrollee completes an application for enrollment through the FFE, makes a plan selection, and enrolls in a QHP with an effective date of January 1. The enrollee is eligible for, and elects to receive the benefit of, APTC, and the portion of the monthly premiums for which he or she is responsible is \$100. The enrollee pays their first month's premium, and coverage is effectuated for January 1. While generating the March billing invoices, the issuer's billing system malfunctions, causing the issuer to fail to bill the enrollee for that month. The enrollee does not pay the March premium, since he or she did not receive a bill. The same malfunction occurs in April, May, June, July, and August; the enrollee does not pay the monthly premiums for any of those months. The issuer uncovers the billing problem while generating invoices for September. The enrollee, who is a resident of State W, owes the issuer \$600 of under-billed premiums in addition to their normal monthly premium payments of \$100. State W instructs the issuer to recoup the under-billed premiums, beginning with the September billing cycle. The issuer allows the enrollee three consecutive months to repay the under-billed premiums. The issuer informs the enrollee that it will bill the enrollee \$300 (normal monthly premium of \$100 plus an under-billed premium installment payment of \$200) for September, October, and November coverage. The enrollee pays the issuer \$300 for coverage in September. On September 14, the enrollee informs the issuer that he or she wishes to terminate coverage effective September 30. The issuer, in accordance with its billing policies and with the rules of State W, immediately bills for the remaining under-billed premiums (\$400) in one lump sum, due on September 30, the date the voluntary termination will take effect. The enrollee receives the accelerated repayment schedule and pays the outstanding under-billed premiums.

Example 7LL: Same facts as Example 7KK but when the issuer bills the enrollee \$400 for the under-billed premiums, due on September 30, the date the voluntary termination will take effect, the enrollee sends payment of \$200 and makes no further payments. Since the enrollee's payment is insufficient to satisfy the outstanding amount of under-billed premiums, the issuer can pursue all options allowed under State W's laws to collect the remaining \$200 from the enrollee.

7.7 Payment Redirect

For the initial enrollment with an issuer, once a QI confirms plan selection at HealthCare.gov, the FFEs enable redirection of the QI from HealthCare.gov to the issuer's payment site, if the issuer provided a payment site in its QHP application. If the QI selects plans from more than one issuer, the FFEs enables multiple payment redirects, with each redirect occurring in a separate window. Payment redirect typically occurs before the FFEs generate the 834 enrollment transaction to the QHP issuer. Therefore, at the time of payment redirect, the QHP issuer often does not have any information on file regarding a QI's plan selection and, if eligible, the APTC amount selected. To address this, the FFEs electronically transfer basic information in the redirection to the issuer's payment portal so the QHP issuer can accept payment. Information sent in the payment redirect includes subscriber information, plan selection, the QI's portion

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of premium due, and the amount of APTC applied to the premium.⁴¹

QHP issuers may, but are not required to, accept payment online. Enrollees similarly are not required to make online payments. CMS considers it a best practice for plans to accept payment immediately to expedite effectuation of enrollments. If a QHP issuer is not capable of accepting online payment at the time of redirect, or elects not to do so, CMS provides standard language to QIs that the issuer will bill them for premium payment.

The FFEs provide the QI with an active payment redirect link, if available from the issuer, until the effective date of the coverage. If a QI completes plan selection via the Marketplace Call Center, or in any case when the QI is not redirected online to the QHP issuer to make an initial premium payment (including where payment is made after the plan effective date but before the premium payment deadline established by issuer), the QI may contact the selected QHP issuer to arrange payment (typically by phone). Since QIs may contact issuers by phone for premium payment or other premium issues, CMS expects QHP issuers' customer service staff to be equipped with telephonic scripts to handle such calls.

Once a QI has paid their portion of the premium and the issuer has sent a confirmation file to the FFEs, the issuer must send the enrollee an enrollment information package consistent with 45 CFR §156.265(e). Appendix A – Sample Welcome Letter, includes an example of the content an issuer might consider including in the cover letter as part of the enrollment package.

7.8 Premium Payment Methods

QHP issuers are required to accept paper checks, cashier's checks, money orders, EFTs, and all general-purpose prepaid debit cards⁴² as methods of payment. Further, according to 45 CFR §156.1240(a)(2), the QHP issuer must present all payment method options equally for a QI to select the preferred payment method.

QHP issuers may accept payment of the initial premium by a method that is exclusive to the initial premium. For example, payment redirect may allow payment of the initial month's premium by credit card, even though the issuer does not accept credit cards as a method of payment for regular, monthly premiums.

Application of premium payment methods must not improperly discriminate against any QI or group of QIs. Issuers may not offer a discount on premiums to QIs who elect a specific type of premium payment method (e.g., EFT). Additionally, issuers may not apply additional fees to QIs based on their choice of valid payment method. For example, an issuer may not pass on administrative fees for processing a premium payment via credit card.

7.9 Payment of Premium by a Third-Party

Under 45 CFR §156.1250, issuers offering individual market QHPs, including QDPs, and their downstream entities, must accept premium and cost-sharing payments on behalf of plan enrollees from the following third-party entities (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost-sharing):

⁴¹ For a complete description of payment redirect, see SBS EXCH EE: 209 Payment Redirect to Issuer Payment Portal Business Service Definition, posted on REGTAP.

⁴² General-purpose prepaid debit cards include those issued by state agencies for the purpose of paying for benefits, including healthcare.

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1. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. An Indian tribe, tribal organization, or urban Indian organization; and
3. A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

If an enrollee or third-party entity notifies the QHP issuer of coordinated premium payment with one of the third-party entities described in 45 CFR §156.1250, issuers should allow for timely premium payment to prevent termination of enrollments for non-payment. If a third-party entity provides notification, the issuer should continue to allow for timely premium payment to prevent termination of enrollments for non-payment.

7.10 Enforcement Discretion Regarding FEMA-Designated Natural Disasters

If issuers comply with any state regulatory authority's request to extend payment deadlines and delay cancellations for non-payment of premium in reaction to a natural disaster or other emergency disruption within a state, CMS may exercise enforcement discretion with regard to regulatory requirements such as the deadline for payment to effectuate coverage and the deadline for payment of premiums under grace periods, including for individuals receiving APTC.

8. TERMINATIONS (APPLICABLE TO THE INDIVIDUAL MARKET FFEs, SBE-FPs, QHPs/QDPs)

A termination is the end of an enrollee's coverage or enrollment in a Qualified Health Plan (QHP) or Qualified Dental Plan (QDP) through an Exchange occurring after their coverage effective date. A termination may be either voluntary (i.e., initiated by the enrollee or the employer) or involuntary (i.e., initiated by the QHP/QDP or the Federally-Facilitated Exchanges [FFEs]). Issuers must notify the Exchange of involuntary terminations. If an enrollee's coverage or enrollment through an Exchange is terminated, the QHP or QDP must provide coverage from the coverage effective date through the termination date.

The QHP/QDP issuer, or the FFEs, can initiate an involuntary termination of an enrollee's coverage or enrollment through the FFEs. A termination can be effective in the future (e.g., for a termination requested by the enrollee), or retroactively (e.g., if the enrollee died, or failed to pay premiums due by the end of a grace period). When an enrollee changes QHPs/QDPs, the termination of the enrollment through the Exchange in the initial QHP/QDP is effective the day before coverage in a different QHP/QDP becomes effective, even in cases of retroactive enrollment.

An Exchange may establish operational standards for QHP and QDP issuers for implementing terminations, cancellations, and reinstatements. See 45 CFR §155.430 regarding terminations of enrollment through an individual market Exchange. The following are operational standards for the FFEs.

Pursuant to 45 CFR 156.270(b)(1), issuers must send termination notices, including the termination effective date and reason for termination, to enrollees for all termination events.

8.1 Enrollee Requested Terminations

In accordance with 45 CFR §155.430(b)(1), enrollees have the right to terminate their coverage or enrollment in a QHP/QDP through an Exchange. Enrollees must request a voluntary termination of their coverage or enrollment through the FFEs. According to §155.430(d)(2), an enrollee who voluntarily terminates coverage or enrollment through the Exchanges, at the option of the Exchange, will be granted same-day or prospective coverage termination dates based on the date of their request. Previously, most enrollees had to give 14 days of advance notice before termination became effective.

Please refer to Section 7.4.4 for guidance regarding terminations during a grace period.

8.2 Termination of an Enrollee's Coverage in the FFEs Due to Death

8.2.1 Terminations from Reported Death

Enrollees who are enrolled through the FFEs or who are application filers should report the death of an enrollee through their HealthCare.gov account or by calling the Marketplace Call Center. This is important because the FFEs conduct redeterminations of eligibility consistent with 45 CFR §155.330 for the remaining members of the household. If a qualified individual (QI) or representative contacts the issuer directly, the issuer should provide the following directions:

- The termination of an enrollee's coverage due to death may be reported by an application filer. If the person taking action to terminate the deceased's coverage is the person who filed the application, he or she can do so online through HealthCare.gov and then contact the Marketplace

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Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to report the date of death (otherwise the termination will be prospective only). Alternatively, an application filer can contact the Marketplace Call Center to both initiate the termination and report the date of death simultaneously. If the application filer does not have access to the online account, the termination of the deceased's coverage can only be initiated through the Marketplace Call Center. A QI who meets the definition of an application filer, as described in 45 CFR §155.20, is allowed to update the application for the remaining members of the household if the deceased filed the application.

- If the individual reporting the death is not an application filer, he or she must submit documentation of death to the FFEs. Individuals in this circumstance should submit documentation directly to the FFEs. Documentation may include a death certificate, obituary, power of attorney, proof of executor, or proof of estate. The documentation, or an attached cover note, should provide the following information:
 - Full name of the deceased;
 - Date of birth of the deceased;
 - FFE application ID (if known) of the deceased;
 - SSN (if known) of the deceased; and
 - Contact information for the person submitting the documentation, including:
 - Full name;
 - Address; and
 - Phone number.

All documentation should be mailed to:

*Health Insurance Exchange ATTN: Coverage Removal
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001*

The Marketplace Call Center will attempt to contact the QI who submits documentation of death regarding the termination of the deceased and reenrollment of any remaining enrollment group members. The remaining QIs or enrollees may need to update tax filing status, financial information, or other information on their FFE applications. These additional changes may qualify the remaining enrollees for a special enrollment period (SEP).

When an enrollee's coverage is being terminated due to death, the issuer receives the appropriate 834 enrollment transaction. The effective date generated by the FFE system will be prospective. The Marketplace Call Center will open a case in the Health Insurance Casework System (HICS) and assign the case to the issuer for retroactive enrollment of the remaining QI so there is no lapse in coverage.

The individual who reports the death should contact the issuer regarding any applicable premium refunds or adjustments. Issuers should process premium refunds or adjustments in accordance with applicable law and existing industry practice.

Example 8A: An enrollee, who is the subscriber in the enrollment group, contacts the FFE on August 7, to report that his wife died three weeks earlier on July 14. As a result of his wife's death, the FFE representative informs the QI that he now qualifies for an SEP. The FFE confirms the date of death and assigns the issuer a Category Two HICS case requesting a retroactive termination date of July 14 for the coverage of the wife.

Additional information about terminations due to death is included in Section 12.5.

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8.2.2 Aging-Off Terminations

Section 2714 of the Public Health Service Act, implemented at 45 CFR §147.120, states that a group health plan or a health insurance issuer offering group or individual health insurance coverage that makes available dependent coverage of children must make such coverage available for children until the attainment of 26 years of age. A state may not have a rule that conflicts with this standard. However, some states have more generous rules that allow certain individuals to remain covered as dependents beyond age 26 if additional criteria are met.

Examples include place of residence, student status, disabled veteran status, marital status, or financial dependence. Information on specific states that extend the age limit beyond 26 is not included in this manual and must be obtained directly from the state's regulatory authority. The FFEs are only operationally capable of applying the maximum adult dependent age rules on its own initiative during the Open Enrollment Period (OEP) or an SEP. The FFEs do not initiate removal of child dependents who reach the applicable maximum age from their original enrollment group until the end of the plan year, or until an SEP.

9. REINSTATEMENTS (APPLICABLE TO INDIVIDUAL MARKET FFEs, QHPs/QDPs)

A reinstatement is the undoing of a termination or cancellation to correct an issuer or Exchange error, or reflect an Exchange Appeals decision, and results in restoration of an enrollment to the original coverage effective date with no break in coverage. Issuers cannot reinstate policies cancelled or terminated by the enrollee or at the enrollee's direction without a Health Insurance Casework System (HICS) case.

Similarly, the reinstatement process requires a HICS case for policies terminated because the Exchange determined the enrollee was no longer eligible for Exchange coverage. Some common permitted reasons for reinstatements are:

- Erroneous Termination/Cancellation of an Enrollment by an issuer;
- Erroneous Termination/Cancellation of an Enrollment Initiated by an Agent or Broker (A/B);
- Erroneous Death Notification;
- Exchange Error/System Limitations;
- Assister Error;
- Directive to Reactivate Individual Coverage Through Granted Appeal.

9.1 Reinstatements in the FFEs

To reinstate an enrollment record, the issuer must submit the reinstatement using an Inbound 834 transaction, through the monthly reconciliation process via the RCNI, or through the dispute process to the Enrollment Resolution and Reconciliation (ER&R) contractor. Although issuers still have the option to utilize the monthly reconciliation and ER&R channel to reinstate a policy, CMS policy is for issuers to use the Inbound 834 reinstatement method whenever possible, as it provides a streamlined and more efficient method for issuers to update the Federally-Facilitated Exchange's (FFE's) enrollment data, with the issuer's enrollment data. In order for a policy to be eligible for an Inbound reinstatement, the policy must have been previously cancelled or terminated by the issuer (without future end date), be from the current or immediately prior plan year (prior year reinstatements typically close in August of the next year), and still be in a terminated or cancelled state in the FFEs. The issuer reactivates the enrollment as if it was never terminated or cancelled, and provides coverage based on the original effective date; maintaining all out-of-pocket accumulators. Regardless of channel (Inbound 834 reinstatement vs. Monthly Recon vs. ER&R), the issuer should submit the reinstatement as soon as possible after they determine that the member was erroneously terminated (see Section 10.3 for more information on submitting through ER&R).

Issuers reinstating a policy via Inbound 834 should not send an Inbound 834 termination/cancellation and an Inbound 834 reinstatement within the same 24-hour time window. This will prevent the possibility of processing both of these transactions in the undesired processing order (i.e. reinstatement processed before termination, when desired outcome was termination processed before reinstatement). Additionally, Inbound 834 reinstatements will only be accepted for policies that have been terminated or cancelled by issuers for reasons of:

- Non-Payment
- HICS Directive
- Fraud

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- Free Look
- Anti-Duplication
- Out-Of-Area
- “Other” (Additional Maintenance Reason Code [AMRC] of CANCEL-OTH or TERM-OTH)

The monthly reconciliation process also only allows issuers to reinstate policies that were terminated or cancelled by the issuer. However, the monthly reconciliation process has a little more flexibility in allowing reinstatements to be processed when there are multiple segments that have coverage dates that overlap. The monthly reconciliation process has logic to cleanup overlaps. Qualified Dental Plans (QDPs) can reinstate policies terminated or cancelled by the consumer, call center, or A/B erroneously through the monthly reconciliation process.

The enrollment dispute process via ER&R will allow issuers to reinstate policies that were terminated by the enrollee, the FFEs, or the issuer. The enrollment dispute process is the only process that can allow reinstatements to be processed when the termination or cancellation is not caused by the issuer, with the exception of QDPs. This process is used when issuers cannot reinstate using Inbound 834 or monthly reconciliation process. Issuers can submit two types of enrollment disputes: HICS Direct Dispute or ER&R Enrollment Disputes Form.

Some common examples issuers may use this enrollment dispute process is:

- If an enrollee’s Qualified Health Plan (QHP) or QDP is erroneously terminated by the Marketplace Call Center, the Marketplace Call Center will generate a HICS case to reinstate the terminated policy due to Marketplace Call Center error
- If an enrollee’s QHP or QDP coverage is erroneously terminated by themselves or someone acting on their behalf with a future termination date (e.g., consumer’s coverage has a termination/end date set for the end of month), but a HICS case was entered before the termination date to reinstate coverage as if never terminated.
- There are also some circumstances where an Appeals determination will ask an issuer to reinstate an Exchange enrollment that was terminated for no longer being eligible (NLE) for Exchange coverage. Issuers must use the HICS direct dispute process to request the reinstatement. These processes are explained more in Section 10.3.

Finally, the enrollment dispute process can process some reinstatements that need to be processed before the updated RCNI is submitted.

- These reinstatements require using the reinstatement tab on the Enrollment Dispute Form.
- These reinstatements require an end date of 12/31.
- This process is only for when the IC834 reinstatement process won’t work (multiple overlapping segments).
- These reinstatements do not require the RCNI to reflect the correct enrollment date and effectuation status.

The Opera and ER&R contractors provide the Marketplace Call Center with reports flagging individuals for whom issuers have submitted reinstatement disputes. The Marketplace Call Center representative advises an impacted enrollee that he or she is still enrolled in the plan and that CMS is working to correct the status in HealthCare.gov. If the impacted member has had a change in circumstance (CIC) and is seeking to update their information with the FFEs, the Marketplace Call Center representative will process as follows, depending on whether the CIC triggers a special enrollment period (SEP):

- If the CIC triggers an SEP, the Marketplace Call Center representative processes the CIC via an

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834 enrollment with a prospective date, by updating the application. Routine overlap clean-up runs eliminate the duplicate coverage, providing the original eligibility for the segment of the enrollment starting January or later, and the post-CIC eligibility for the policy segment going forward.

- If the CIC does not trigger an SEP, the Marketplace Call Center representative will process the CIC by creating a HICS message that will state, *“Reinstatement is pending, so CIC is sent via HICS. HICS case may be closed after issuer processes the CIC.”*

The FFEs regularly send reinstatement requests from individuals to issuers via HICS. CMS expects issuers to review these matters and determine if issuer error occurred warranting a reinstatement.

10. ENROLLMENT DATA ALIGNMENT (APPLICABLE TO INDIVIDUAL MARKET FFEs, QHPs/QDPs)

Pursuant to 45 CFR §155.400(d), the Federally-Facilitated Exchanges (FFEs) are required to reconcile enrollment records with all participating issuers on a monthly basis. Reconciliation ensures that Qualified Health Plan (QHP) issuers, Qualified Dental Plan (QDP) issuers, and the Exchanges have equivalent enrollment information. Accurate enrollment information allows CMS to make correct payments for advance payments of the premium tax credit (APTC), and to assess FFE user fees. It also prevents multiple enrollments by one individual and ensures that the data used for analytics and metrics are accurate.

The intent of this section is to provide issuers with an overview of the enrollment reconciliation processes in order to successfully complete enrollment reconciliation with CMS on a monthly basis. Participation in enrollment reconciliation is essential for data consistency and to support correct policy-based payments. FFE Enrollment data consistency between CMS and issuers is ensured by IC834 Transactions, Enrollment Reconciliation, and the Dispute Resolution process.

IC834 (Inbound 834) should always be used whenever possible to make basic updates to the status of an enrollment. Although certain data may be updated by both IC834 and monthly reconciliation, IC834 provides a faster update to the policy and is the preferred method of Enrollment Data Alignment. These transactions must pass stringent data quality checks and do not allow issuers the flexibility to change certain data elements, such as the Benefit Start Date. The following data elements may be updated using IC834 with the respective transaction type:

- Effectuation Status (Confirmation Indicator): Effectuation, Cancellation
- Issuer-Assigned Subscriber, Member, and Policy ID: Effectuation, Maintenance (ICM834)
- Benefit End Date & Financial End Dates: Cancellation, Termination
- End of Year Termination Indicator: Termination
- Last Premium Paid Date: Effectuation
- Superseded Indicator: Termination
- *Reactivate Coverage: Reinstatement

*In order for an Inbound 834 reinstatement to be accepted, the policy the issuer wishes to reinstate must have been previously terminated or cancelled by the issuer and remain in an issuer-initiated cancelled or terminated status in the FFE system.

Monthly Enrollment Reconciliation is an analytical process with greater flexibility to update policies. While issuers can update the same data elements through ER&R disputes, monthly reconciliation should be leveraged in all available instances that cannot be handled through IC834 before attempting to update through ER&R. Files must pass basic formatting checks and meet requirements based on enrollment policy and technical business rules before updates are made to the FFEs. Please refer to Section 10.3.

Issuers should use the monthly reconciliation process primarily to update the following fields:

- Benefit Coverage and Financial Dates
- Tobacco Use Status
- Total Premium Amount
- Enrollee Mailing Address

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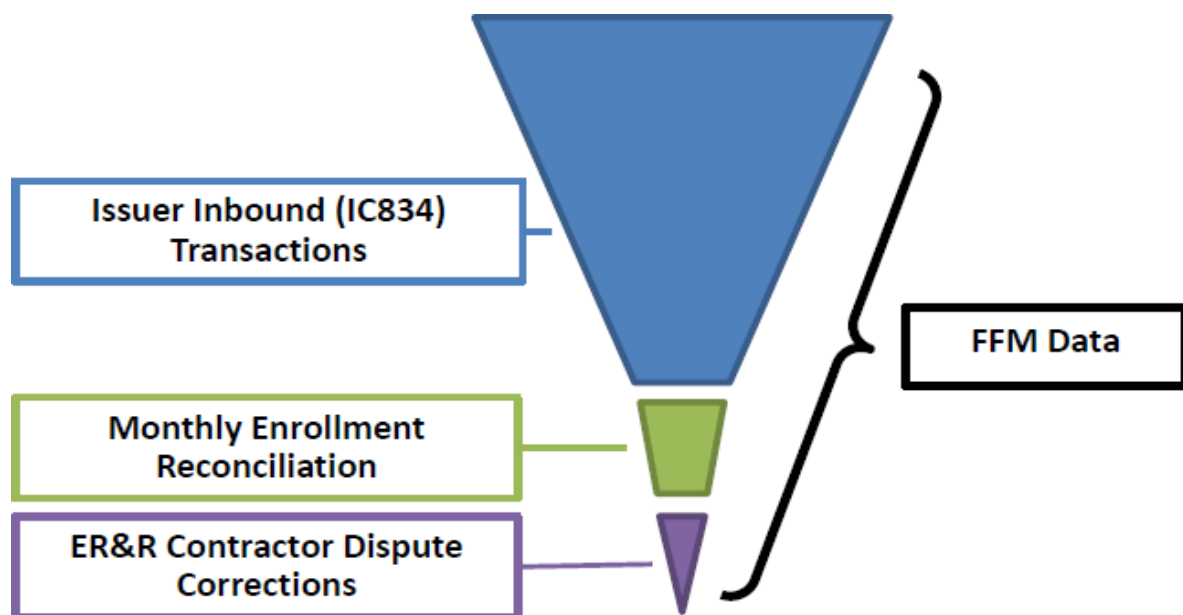
- Agent/Broker Information

Resolution of Enrollment and Payment Discrepancies (Disputes) corrections may involve manual inspection of a policy by the Enrollment Reconciliation & Resolution (ER&R) contractor, and direct contact with issuer, and should represent the smallest contingent of enrollment updates. Please refer to Section 10.3.

Though issuers can provide an update to the FFEs through any of these processes, issuers should prioritize the IC834 process to make data updates. The IC834 transactions are processed on a daily basis and are the best way to ensure the FFEs are updated timely. The monthly reconciliation process should only be used to update the FFEs in situations where the IC834 process is unable to make the necessary updates. The Dispute process should be utilized for prior year disputes when the enrollment reconciliation and IC834 processes have ended, and for data scenarios that cannot be resolved via IC834 or the monthly reconciliation process.

Exhibit 20 represents the volume of policy updates performed by each component of enrollment in the FFEs.

Exhibit 20: Volume of Policy Updates Performed



Additional information can be found in the private issuer community on CMS zONE here:

<https://zone.cms.gov/document/inbound-834>

<https://zone.cms.gov/document/enrollment-data-reconciliation>

<https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>

NOTE: Issuers will need to log in to CMS zONE to access these links.

10.1 Inbound 834 (IC834)

ASC X12 834 transactions between the FFEs and issuers are conducted in two fashions: outbound 834 (FFEs to issuer) and inbound 834 (issuer to FFEs). Inbound 834 processing (IC834) represents issuer responses to enrollment activity in the Exchange and should be used by the issuer community whenever possible as the first and best means of updating and aligning the enrollment data stored in the FFEs, with the issuer's current enrollment data. An issuer's submission of an IC834 to the FFEs communicate payment/non-payment in the issuer's system, as well as other updates, by using one of five possible Inbound enrollment transactions:

1. Effectuation-typically generated after the issuer has received initial enrollment information from the FFEs in the form of an Initial 834 (I834), and additionally, the issuer has received a binder payment from a new subscriber, and the policy has been made active in the issuer's system/records.
2. Cancellation-typically generated when the enrollment is ended with no actual coverage for enrollee(s) due to non-payment.
3. Termination-typically generated following an effectuation when the enrollment is ended after some period of coverage for enrollee(s) due to non-payment, fraudulent activity, directive from a Health Insurance Casework System (HICS) case, or other reasons.
4. Inbound Maintenance-typically generated following an effectuation to update the Issuer-Assigned IDs on file for the FFE policy (Issuer-Assigned Policy ID, Issuer-Assigned Subscriber ID, and Issuer-Assigned Member ID).
5. Reinstatement-typically generated following an inadvertent or erroneous issuer-driven termination or cancellation to re-activate coverage for the FFE policy.

The intended result of IC834 transaction processing is a policy being updated in the FFEs, and in order to ensure timely updates are made, IC834s are processed continuously throughout the day. However, IC834 submissions must pass stringent data quality checks and do not allow issuers the flexibility to change certain data elements, such as the Benefit Start Date. The first validations occur at Electronic Data Interchange (EDI) level. EDI platform performs standard Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process Group (SNIP) Levels 1–7 validation on the EDI formatted data elements. If the IC834 passes EDI validation, the issuer will receive positive Interchange (TA1) and Functional Group Level (999) acceptance acknowledgement, and the X12 IC834 will be converted to an XML file and sent to the FFEs for further processing. If the IC834 fails EDI validation, issuers will receive a negative TA1, and the file will not be passed to the FFEs for further processing.

Once the XML has been generated, the transactions are sent to the FFEs. At this point, the second level of validation occurs, and includes checks for matching elements (e.g. benefit start date, policy numbers, policy status in FFEs, etc.). If the IC834 contains errors, issuers will receive a rejected Business Application Acknowledgement (BAA) XML file with error codes, which correspond to a specific error(s) found within the IC834. The BAA will assist issuers in determining what data is incorrect for their IC834 submission, and aid in correctly modifying that data so the rejected IC834 can be resubmitted. If no rejected BAAs are generated, the IC834 will successfully update the FFEs database. BAAs are aggregated and sent daily to issuers around 2pm ET. Issuers can expect to receive BAAs for submissions made the previous day. Issuers should be aware that positive BAAs are not sent to issuers. If an issuer does not receive negative BAAs for their IC834 submissions, and has received positive TA1 and 999 acknowledgements, the submissions can be considered successfully received and processed by the FFEs. Additionally, issuers are able to review their IC834 submission metrics through receipt of a weekly

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Production Operation Summary Report (PO Report). This report contains transactional details, such as total accepted and rejected IC834 submissions, and granular data on the reason for rejected BAAs. PO Reports are sent weekly to issuers (typically on Wednesday) and contain IC834 submission data from the previous week (Tuesday to Monday). The Electronic File Transfer (EFT) function code for the PO Reports is OP834T.

As previously mentioned, IC834 should be used by issuers to perform updates to enrollment data in the FFEs whenever possible. However, there are instances when certain data cannot be updated via IC834, or certain scenarios prohibit the use of IC834. In these cases, issuers should utilize the Enrollment Reconciliation or ER&R channels in order to make the necessary enrollment data updates.

For more information on Inbound 834 (IC834), please refer to the following guidance:

- IC834 CMS zONE Page: <https://zone.cms.gov/document/inbound-834>
- Maintenance 834 Operations Manual: <https://zone.cms.gov/document/federally-facilitated-marketplace-maintenance-834-operations-manual>
- Benefit Enrollment and Maintenance (834) Transaction Companion Guide: <https://zone.cms.gov/document/asc-x12-005010-834-companion-guide>
- ASC X12 TR3 5010 | 834 Benefit Enrollment and Maintenance Implementation Guide (Due to copyright laws, this guide must be purchased directly from X12)

For questions or inquiries about IC834, please contact: Inbound834@bah.com.

10.2 Enrollment Reconciliation & Pre-Audit Files

FFE's Enrollment Reconciliation is a monthly process, starting each month with a comprehensive extract of the FFE's enrollment data that is pulled 6PM Eastern Time on the 15th of every month. This extract provides a "snapshot" of enrollment data in the FFEs for enrollment and payment purposes. It is then formatted and distributed to each QHP and QDP issuer as an Enrollment Pre-Audit File. The Enrollment Pre-Audit File is not in EDI 834 format; it is a pipe-delimited flat file that issuers may choose to process directly or convert into a readable format such as Excel.

Each Enrollment Pre-Audit File refers to a distinct plan year, is aggregated by Trading Partner ID and transmitted to issuers via EFT. These files are delivered to the same location an issuer receives daily EDI 834 traffic. Enrollment Pre-Audit Files can be identified by the function code AUDYY (where YY is the final two digits of the plan year referenced by the file) for plan years 2017 and earlier, or AUDY (where Y is the final digit of the plan year referenced by the file) for plan years 2018 or later.

Upon receipt of an Enrollment Pre-Audit File, the issuer should compare the file to the enrollment data in the issuer's system and process any enrollments or updates from the pre-audit file that are missing or incorrect in the issuer's system. If CMS has determined that a specific enrollment action failed to convey to the issuer via standard EDI 834 transaction, the corresponding enrollment record(s) in the Enrollment Pre-Audit File will be flagged in the Missing Outbound 834 Indicator field. Issuers should closely review these records and apply the necessary updates to their system each month.

Likewise, if an EDI 834 transaction failed but was later successfully retransmitted to the issuer via I834RT File, the corresponding enrollment record(s) on the Enrollment Pre-Audit File will be flagged as such. Issuers should ensure the enrollment updates have been made in their system either via the I834RT file or the Enrollment Pre-Audit File.

Also, as part of monthly Pre-Audit processing, CMS identifies instances of overlapping or duplicate

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coverage for the same individual across the FFEs. In cases of duplicate or overlapping coverage, CMS will align the enrollment records (with deference to the latest action taken by the enrollee) to eliminate the overlap or duplicate record. This may result in adjustment of benefit coverage dates or cancellation of an enrollment span on the FFEs. Enrollment records that have been adjusted by the overlap process are flagged accordingly on the Enrollment Pre-Audit File with an indicator that informs the issuer as to whether the overlap was within the same Health Insurance Oversight System (HIOS) ID or with a different HIOS ID. **Issuers must act upon the cancellations and terminations flagged on the Pre-Audit File as this information will not be sent via EDI 834.** Records impacted by the overlap cleanup are only flagged in the month where the overlap was corrected; as such, issuers must address the records flagged by the cleanup on every Pre-Audit File received from the FFEs.

CMS also conducts a monthly date of birth (DOB) cleanup process. When a DOB change is entered in the FFE, the DOB and premium are adjusted as needed going forward, but no update is made to the historical records for that plan year. The DOB cleanup process rolls back the changes to prior policies and policy segments on the same application. If the DOB change on the historical update would cause a change in premium, the premium adjustment and DOB will be applied to historical records. If the premium on the historical record had been previously updated through reconciliation, a DOB change will be made but no update to the premium will be applied. Issuers should note that APTC will only be adjusted by this cleanup if the new Total EHB (essential health benefit) Premium would be lower than the Applied APTC Amount; in that case the Applied APTC Amount would be lowered to match the new Total EHB Premium.

As with the overlap cleanup process, issuers will only receive notification of adjustments made by the DOB cleanup on the monthly Pre-Audit File. **Issuers must act upon the DOB and any financial changes flagged on the Pre-Audit File as this information will not be sent via EDI 834.** Records impacted by the DOB cleanup are only flagged in the month where the historical records were corrected; as such, issuers must address the records flagged by the cleanup on every Pre-Audit File received from the FFEs.

For additional guidance and technical specifications for the Enrollment Pre-Audit File, please refer to the Enrollment Reconciliation section in the private issuer community on CMS zONE, located at <https://zone.cms.gov/document/enrollment-data-reconciliation>.

Specifications for Standard Issuer Enrollment Data Files are may be found at the above link.

In order to identify discrepancies and reconcile enrollment data with the FFEs, each month issuers are required to similarly extract their enrollment data by plan year and submit an Inbound Enrollment Reconciliation (RCNI) File to the FFEs. They must submit them by the deadline outlined on the External Reconciliation calendar located at <https://zone.cms.gov/document/pre-audit-and-recon-calendar-and-file-specification>.

As with the Enrollment Pre-Audit File, the RCNI File is a pipe-delimited flat file that will be submitted to the FFEs via Electronic File Transfer (EFT). The RCNI File is a snapshot of the issuer's enrollment data for a specific plan year and must include information about current enrollees, cancelled enrollment records, and terminated enrollments. The RCNI Files include both enrollment and financial data elements. The enrollment data submitted by the issuer on the RCNI File should be aligned to transactions received from the FFEs through the date of that month's FFEs Pre-Audit Extract (typically the 15th of the month)

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to reduce timing issues when compared to the FFE's data. For additional guidance and technical documentation on the RCNI, please refer to the Enrollment Reconciliation section in the private issuer community on CMS zONE, located at <https://zone.cms.gov/document/enrollment-data-reconciliation>.

CMS compares the data extracted from the FFE's Extract to each issuer's RCNI Files through an automated process. The automated process matches records based on a unique collection of field information and identifies discrepancies between issuer data and the FFE's data. This process uses current enrollment policy rules to determine if the discrepancy needs to be resolved in the FFEs or by the issuer (or in some cases both the FFEs and the issuer must update a value). The results of the record-matching and data comparison are distributed to issuers in a file called the Outbound Enrollment Reconciliation (RCNO) File. The RCNO File provides record-level flags on each record to show the results of matching and highlight records on which the FFEs or issuer are expected to take action; field-level flags are also provided on matched records in the file to show the results of field-level data comparison and, if necessary, which system is expected to update to the other's value.

As with the Enrollment Pre-Audit File, each RCNO File is aggregated by Trading Partner ID and transmitted to issuers via EFT. These files are delivered to the same location an issuer receives daily EDI 834 traffic. RCNO Files can be identified by the function code RCNOYY (where YY is the final two digits of the plan year referenced by the file) for plan years 2017 and earlier, or RCNOY (where Y is the final digit of the plan year referenced by the file) for plan years 2018 or later.

For additional information on the business rules used in automated reconciliation and the record and field-level flags on the RCNO File, please refer to the Enrollment Reconciliation Education Suite located in the private issuer community on CMS zONE at <https://zone.cms.gov/document/enrollment-data-reconciliation>.

It is expected that issuers will correct the enrollment data in their systems based on the updates specified for the issuer in the RCNO File. If the issuer disagrees with a discrepancy resolution flag set by the automated process or needs to resolve a discrepancy in a way that cannot be done through automated reconciliation, they may submit a dispute to the ER&R contractor for resolution.

Please refer to Section 10.3 for additional guidance on the ER&R dispute process.

10.3 Resolution of Enrollment and Payment Discrepancies (Disputes)

As described in Section 10.2, CMS regulations and guidance require issuers that participate in the FFEs to reconcile their records monthly. The monthly enrollment reconciliation process is an automated process to compare the FFE's data to the issuer enrollment records to determine any discrepancies. This process uses current CMS enrollment policies and technical business rules to determine when the FFE's records may be updated and when the issuer should update their system to match the FFEs. If an issuer disagrees with a decision made in the automated monthly reconciliation process, they can file a dispute to the ER&R contractor. The ER&R contractor is responsible for resolving issuer-initiated enrollment and payment discrepancies that cannot be resolved through the automated reconciliation process or the IC834 process.

ER&R applies automated and manual rules to ensure disputes are resolved in accordance with approved enrollment and payment guidelines. Following the resolution of any discrepancies, the ER&R contractor submits changes to the FFEs or notifies issuers to update their respective data. Issuers see updates to the FFEs reflected on the Pre-Audit File within 1–2 payment cycles.

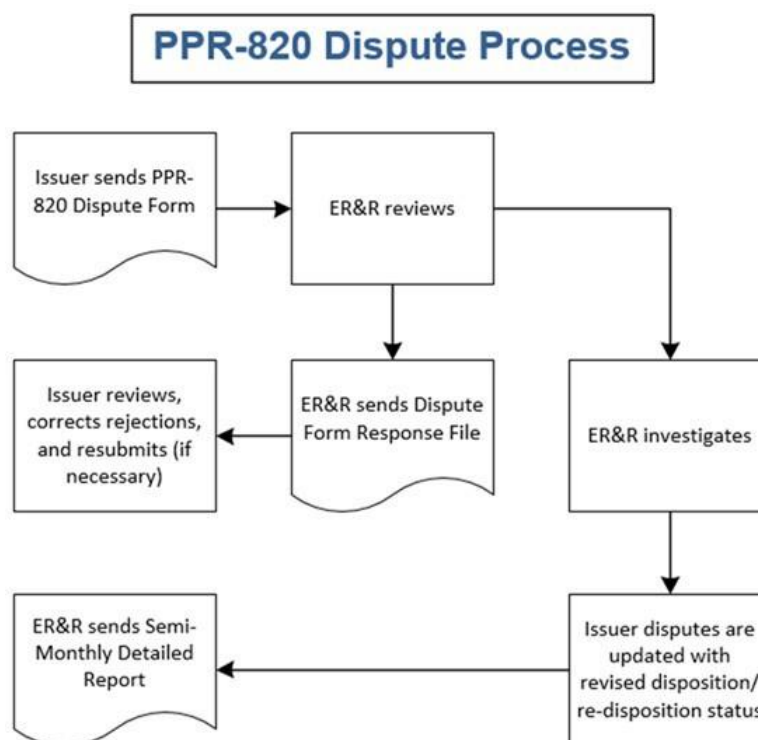
Issuers are strongly encouraged to submit disputes as soon as possible upon identification of a

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discrepancy, to help ensure the FFEs issue an accurate Form 1095-A to individuals in advance of the tax filing deadline, as well as ensure proper and timely payments. To help ensure payment and enrollment disputes are processed in the same cycle (when possible), issuers should submit disputes by the deadline identified on the External Reconciliation Calendar located at <https://zone.cms.gov/document/pre-audit-and-recon-calendar-and-file-specification>.

10.3.1 Payment Disputes

Exhibit 21: PPR-820 Payment Dispute Process



Issuers can submit disputes through three different avenues: 1) Payment Disputes, 2) Enrollment Disputes, or 3) HICS Direct Disputes. The Payment Dispute (PPR/820 disputes) process allows the issuer to submit unexpected or missing payments identified in the PPR or HIX 820. It is important to note that the Policy-Based Payment process became active in 2016. Therefore, disputes for years prior to 2016 cannot be submitted through the Payment Dispute process and must be submitted through the Enrollment Dispute process.

To submit a Payment Dispute, the issuer should submit the Financial Transfers (FT) PPR-820 Dispute Form (Payment Disputes Form) to the ER&R contractor in an Excel or Pipe Separated Value (PSV) format. Issuers must submit the PPR/820 Dispute Forms via EFT, which uses the same EFT setup as the 834/820 file transfer process. Issuers must complete the dispute form using data from either the PPR or the HIX 820. For additional information on how to submit Payment Disputes to the ER&R contractor, including the naming conventions, file specifications and additional guidance, please refer to the *Combined Enrollment and Payment Disputes TRG* located on CMS zONE at <https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>.

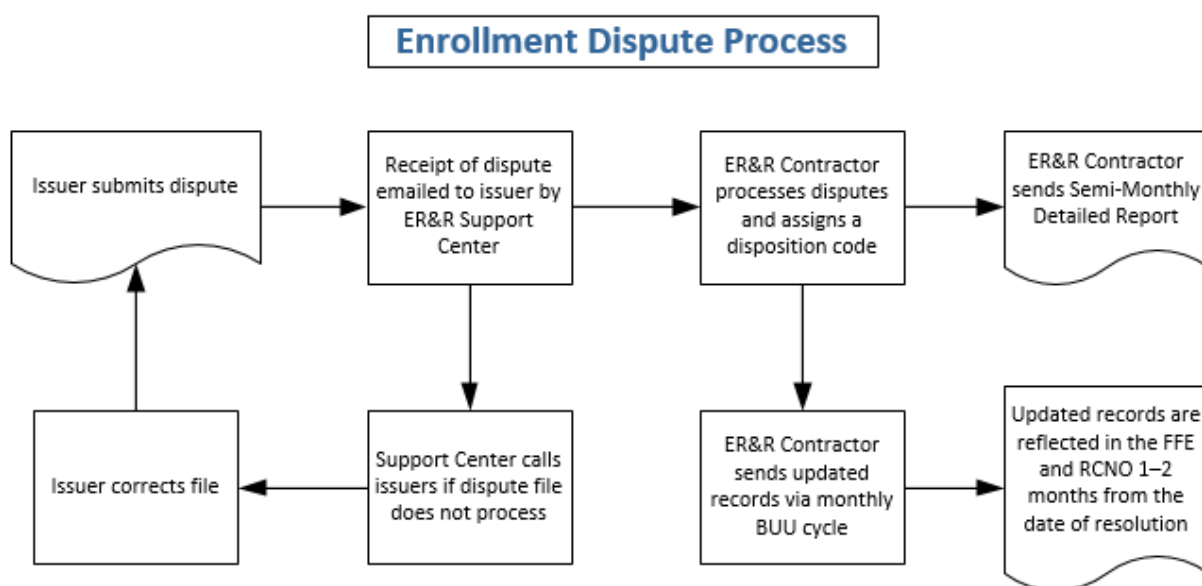
When an issuer submits the Payment Dispute Form, they will receive a PPR/820 Dispute Response File

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within 1–2 business days. The response file provides the results for each dispute submitted. If a dispute is flagged with an *In Process/In Analysis* disposition code, the issuer will need to monitor the Semi-Monthly Detailed Reports for updates. These reports provide dispositions for Enrollment, Payment and HICS Direct disputes and are provided bi-monthly on the 1st or the 16th (or the first business day thereafter). For additional guidance on the Response File and the Semi-Monthly Detailed Reports, including the disposition codes and descriptions, please refer to the *Payment Dispute Disposition and Detail Code List* located at <https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>.

10.3.2 Enrollment Disputes

Exhibit 22: Enrollment Dispute Process



The Enrollment Dispute process allows issuers to submit disputes based on enrollment data found on the Pre-Audit or RCNO. Issuers can use this process to submit disputes for any year. As of May 1, 2019, issuers must first receive approval from their Account Manager (AM) before any Prior Year disputes can be submitted to ER&R. Each subsequent coverage year will require AM approval as of 05/01 of the following year. Disputes caused by a HICS case do not require AM approval. The issuer will need to submit the HICS case, as appropriate, directly to the ER&R contractor or provide the HICS case number on the dispute form.

To submit an Enrollment Dispute, issuers should submit the Enrollment Dispute Form in an Excel or PSV format similar to the payment dispute form. Issuers must also submit the Enrollment Dispute form through EFT. There are 10 tabs on the dispute form. The first three are guidance and instructions. The other seven tabs on the enrollment dispute form are for issuers to fill out to submit corrections. These tabs are:

1. Discrepancy Dispute Tab – Allows issuers to dispute discrepancies identified on the RCNO.
2. Rejected Enrollments Tab – Allows issuers to reject FFE enrollments, including Batch Auto-Reenrollment (BAR) enrollments.
3. Reinstatement End Date 12.31 Tab – Allows issuers to reinstate policies to a 12/31 end date.
4. Newborn Premium Updates – Allows the issuer to report a newborn member who qualifies for a free premium coverage period in accordance with applicable state laws.

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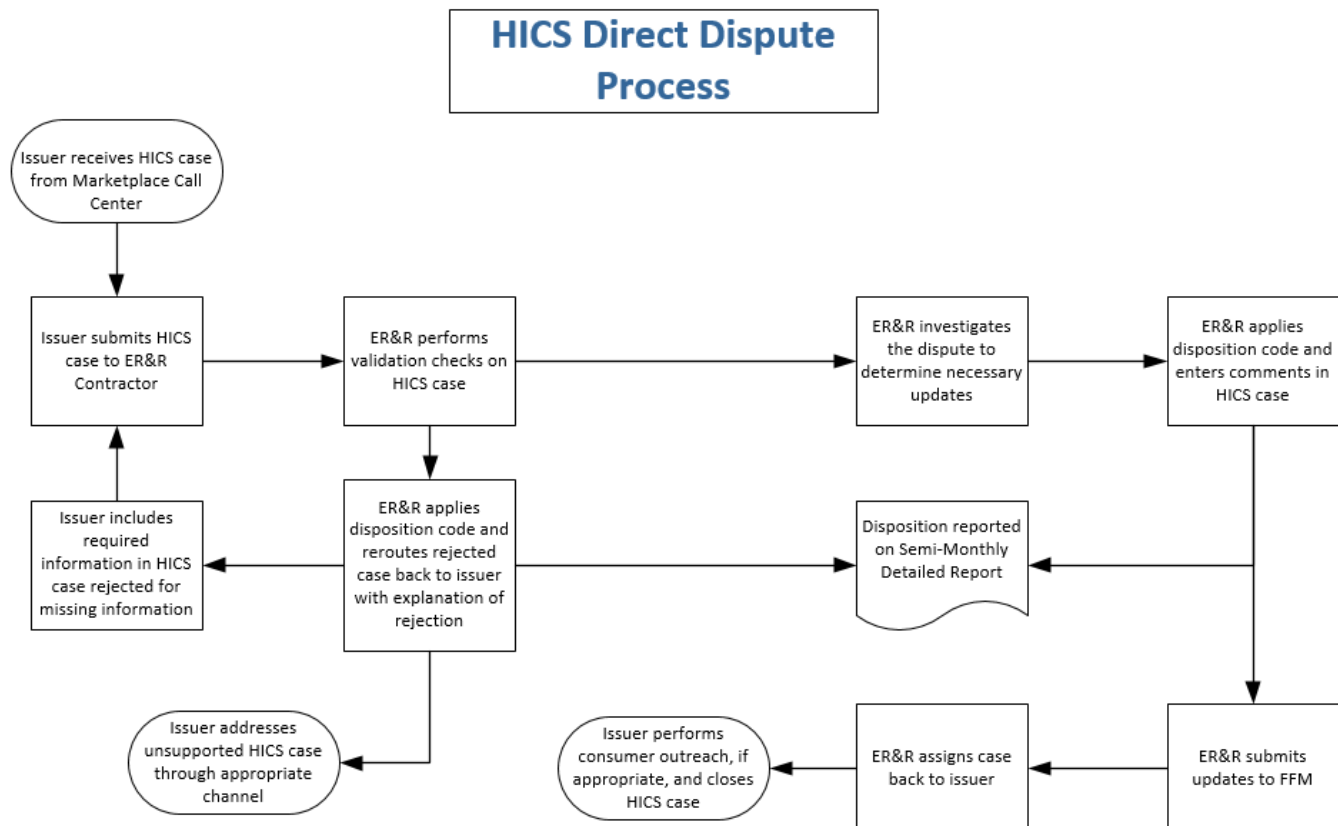
5. Enrollment Blocker Tab – Allows issuers to update financial information or other enrollment information when an error occurs in the FFEs.
6. Mailing Address Change – Allows issuers to update mailing addresses.
7. Agent Broker Information – Allows issuers to add, change or remove Agent or Broker (A/B) information.

It is important to note that the data submitted on the RCNI must match the data the issuer submits on the Enrollment Dispute Form. However, policies submitted on the Rejected Enrollment, Reinstatement End Date 12.31, and Enrollment Blocker Tab do not require the data to match on the RCNI prior to submission. For additional information on how to submit Enrollment Disputes to the ER&R contractor, including the naming conventions, file specifications and additional guidance, please refer to the *Combined Enrollment and Payment Disputes* TRG located on CMS zONE at <https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>.

Enrollment Disputes do not get a response file within 1–2 business days. The status of an Enrollment Dispute is reported on the Semi-Monthly Detailed Reports. As mentioned previously, these reports provide dispositions for each disputed record for Enrollment, Payment and HICS Direct disputes and are provided bi-monthly on 1st or the 16th (or the first business day thereafter). For additional guidance on the semi-monthly detailed reports, including the disposition codes and descriptions, please refer to the FFEs Payment Disposition and Detail Code List located at <https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>.

10.3.3 HICS Direct Dispute Process

Exhibit 23: HICS Direct Dispute Process



The HICS Direct Dispute process allows issuers to submit a HICS case they receive directly to the ER&R contractor. This process allows issuers to reassign HICS cases to the ER&R contractor. The HICS case will remain open while it is pending with the ER&R contractor, and the time while the case is pending with ER&R does not count toward the HICS resolution timeframes (72 hours for Priority 1 and 15 days for Priority 2). Time begins to run again once ER&R returns the HICS case to the issuer. This allows the issuer time to complete the necessary actions on the HICS case before closing it.

Most updates can be made through the monthly reconciliation process. There are limited situations that require HICS cases to be directly disputed to the ER&R contractor for manual review and processing. HICS Direct Disputes are, as of publication of this Manual, limited to the following updates:

- Financial Updates due to an Enrollment Blocker
- Changing Subscriber Dispute
- Date of Birth Dispute
- Applied APTC Amount
- Total Premium Amount

NOTE: Total Premium Amounts that do not require a HICS case are not eligible for Direct Dispute processing. For additional information on which updates require HICS cases, access the Combined Enrollment and Payment Disputes TRG located at

<https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>.

- Term NLE Appeals

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- QHP ID/Variant ID
- Removal of a Member

For additional information on how to submit HICS Direct Disputes to the ER&R contractor, including steps on transferring HICS files additional guidance on what can be submitted through this process, please refer to the *Combined Enrollment and Payment Disputes TRG* located on CMS zONE at <https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>.

HICS Direct Dispute responses are included in the comments of the HICS case when it is returned to the issuer. ER&R also applies a disposition code to each HICS Direct Dispute Case in the comments section of the HICS case as well as on the Semi-Monthly Detailed Report. As mentioned previously, these reports provide dispositions for each disputed record for Enrollment, Payment, and HICS Direct disputes and are provided bi-monthly on the 1st or the 16th (or the first business day thereafter). For additional guidance on the semi-monthly detailed reports, including the disposition codes and descriptions, please refer to the *CCIIO Enrollment Disposition Code* located at <https://zone.cms.gov/document/enrollment-resolution-and-reconciliation>.

11. FORM 1095-A GENERATION AND CORRECTIONS

11.1 Form 1095-A Initial Generation Process

Throughout January each year, the Federally-Facilitated Exchanges (FFEs) generate and send initial Forms 1095-A to tax filers who enrolled in a QHP through the FFEs during the prior year. The Form 1095-A provides enrollees with information about their health coverage so that application tax filers can:

- File their taxes,
- Reconcile advance payments of the premium tax credit (APTC), and
- Claim the premium tax credit (PTC).

The information provided on a Form 1095-A is used to complete Form 8962 with the Internal Revenue Service (IRS). Application tax filers must complete and file a Form 8962, regardless of whether they are required to file a tax return, to claim PTC, or be eligible for APTC in future years.

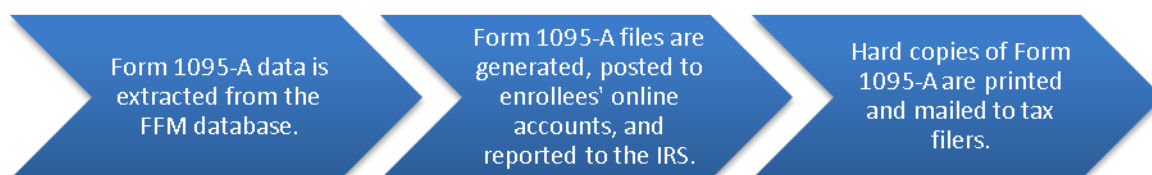
As part of this program, the FFEs send IRS monthly and yearly data regarding all individual enrollment and APTC payments made to QHP issuers on behalf of enrollees, which IRS uses when processing individuals' Federal income tax returns (e.g., to reconcile APTC, process PTC claims, and grant exemptions). Annual reports are submitted to IRS following completion of the coverage year, identifying tax-filers or other relevant adults who received APTC (or whose tax dependent(s) received APTC) related to an individual market policy purchased through the Exchange. The IRS uses the information in the annual reports to verify information included on individual-submitted Form 8962.

The purpose of Corrections Cycles is to process individual initiated corrections to FFEs record to enable the FFEs to produce corrected forms for any policy/application whose relevant data have changed. The Form 1095-A corrections process addresses various errors reported by enrollees through the Marketplace Call Center. The corrections form generation process also picks up any data changes submitted by issuers via IC834s, the Data Reconciliation process, and Enrollment Resolution and Reconciliation (ER&R) disputes. These issuer-initiated updates generate corrected Forms 1095-A and individuals may be required to file an amended Federal income tax return. Approximately 70% of corrections are driven by issuer-initiated data changes.

Form 1095-A data is populated from the FFEs enrollment data submitted to IRS, and initial generation occurs on a rolling, state by state basis, which leads to:

- Forms 1095-A being generated electronically, and posted to enrollee's online accounts;
- Hard copies being printed and mailed to tax filers; and
- Form 1095-A data is reported to the IRS.

Exhibit 24: Form 1095-A Generation Process Overview



Issuer participation in the ER&R process (discussed in Section 9 of this manual) is an essential part of

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ensuring accuracy of Form 1095-A data. CMS performs enrollment data alignment with issuers to ensure FFEs records match QHP issuers' records. If the data is not correct, there are important tax implications, such as enrollees receiving Forms 1095-A with incorrect coverage data that can impact their APTC/PTC reconciliation. Please note the FFEs do not send Forms 1095-A to enrollees only enrolled in dental or catastrophic coverage.

Timeliness of issuer reconciliation is critical. The initial Form 1095-A generation process typically begins in early January each year and leverages the data captured in the FFEs up through the current month when Forms 1095-A are generated. As such, all issuer data should be reconciled each year by the end of November to ensure Form 1095-A data is accurate on individual's initial Forms 1095-A.

If Form 1095-A data is updated in the FFEs database, after initial Form 1095-A generation, Corrected and/or Voided Forms 1095-A are automatically generated and mailed to enrollees. This leads to enrollee confusion, since enrollees are likely not expecting to receive a new Form. CMS provides the following guidance to avoid enrollee confusion.

CMS strongly recommends that issuers reconcile enrollment data by November to limit enrollees receiving Forms 1095-A with incorrect coverage data that can impact their APTC/PTC reconciliation.

As discussed in Section 10.3, ER&R accepts and resolves disputes from issuers for prior years. Issuers are strongly encouraged to submit disputes as soon as possible upon identification of a discrepancy to allow the FFEs to issue accurate Forms 1095-A to enrollees in advance of the tax filing deadline.

11.2 Examples

Example 11A: CMS or an issuer identifies an enrollment data error that affects a high volume of policies for a particular Health Insurance Oversight System (HIOS) ID after the coverage year ends but while prior year reconciliation cycles are still active.

Recommended issuer action: While prior year reconciliation cycles are still active (through March of the benefit year following the end of the enrollee's coverage period), updates can be made via automated reconciliation or if appropriate, dispute resolution. Once reconciliation is complete, Corrected or Voided Forms 1095-A will be automatically generated during the next Form 1095-A Correction Cycle and sent to affected enrollees. In this scenario, it will take approximately 1–2 months for enrollees to receive their corrected Form 1095-A.

NOTE: If this scenario occurs after prior year reconciliation cycles are completed issuers are strongly encouraged to contact each affected enrollee so they know to expect a Corrected or Voided Form 1095-A. CMS has developed the Issuer Outreach Toolkit to assist issuer in conducting Form 1095-A related enrollee outreach. The Toolkit is available on CMS zONE at https://zone.cms.gov/system/files/documents/toolkit_for_issuers_form_1095-a_final_clean.pdf.

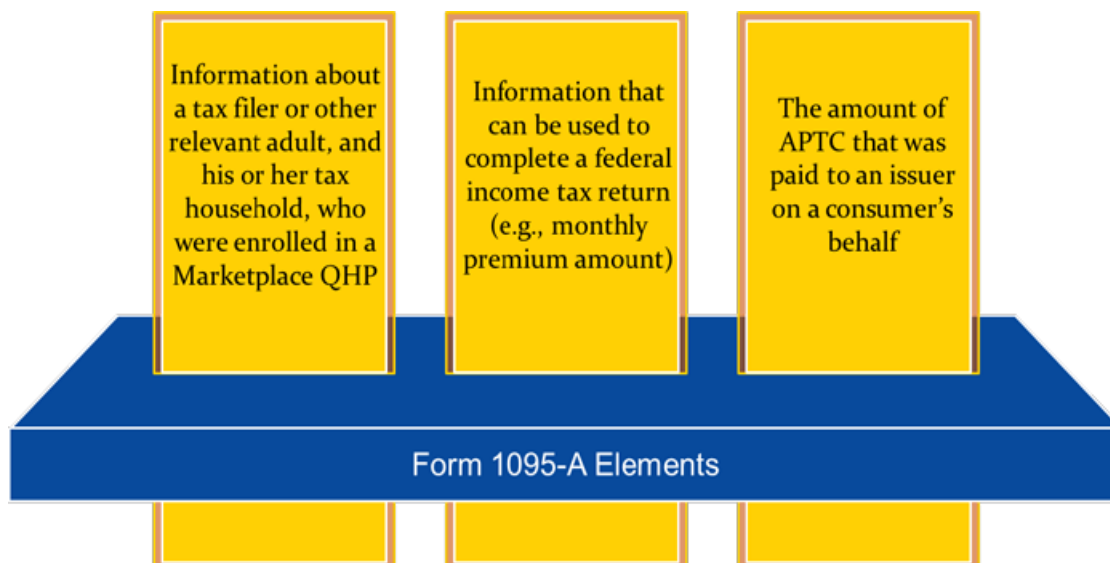
Example 11B: CMS or an issuer identifies a single policy that requires coverage date changes.

Recommended issuer action: The issuer can submit this type of enrollment through the ER&R Dispute process (see Section 10.3.) Up to five weeks after dispute resolution, issuers receive a past year pre-audit file reflecting the changes accepted by the FFEs.

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11.3 Anatomy of a Form 1095-A

Exhibit 25: Form 1095-A Elements



11.3.1 Form 1095-A Part 1: Recipient Information

Part I, lines 1–15, reports information about:

- The tax filer or other relevant adult
- The insurance company that issued the policy
- The Marketplace where they enrolled in coverage

Exhibit 26: Recipient Information Section

Part I Recipient Information			
1 Marketplace identifier	2 Marketplace-assigned policy number	3 Policy issuer's name	
4 Recipient's name		5 Recipient's SSN	6 Recipient's date of birth
7 Recipient's spouse's name		8 Recipient's spouse's SSN	9 Recipient's spouse's date of birth
10 Policy start date	11 Policy termination date	12 Street address (including apartment no.)	
13 City or town	14 State or province	15 Country and ZIP or foreign postal code	

11.3.2 Form 1095-A Part II: Covered Individuals

Part II, lines 16–20, reports information about each individual who is covered under the tax filer's or other relevant adult's policy, including:

- Covered individual name, Social Security number (SSN), and date of birth
- Coverage start and end date

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Exhibit 27: Covered Individuals Section

Part II Covered Individuals					
	A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16					
17					
18					

11.3.3 Form 1095-A Part III: Coverage Information

Part III, lines 21–33, reports information about the tax filer’s insurance coverage that they will need to complete Form 8962 to claim the PTC and reconcile APTC, including monthly:

- Enrollment premiums
- Second Lowest Cost Silver Plan (SLCSP) premium
- APTC

Exhibit 28: Coverage Information Section

Part III Coverage Information			
Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January			
22 February			
23 March			

*Individuals may not recognize the monthly premium amount (included in Part III, Column A) listed on Form 1095-A:

- Because the monthly premium amount is reduced for premiums allocated to benefits exceeding essential health benefits (EHB)
- If individuals were also enrolled in a Qualified Dental Plan (QDP), the monthly premium amount also includes the pediatric, EHB portion of QDP monthly premium amounts
- If issuers prorated the monthly premium for enrollees in cases such as mid-month additions (e.g., birth/adoption) or mid-month terminations (e.g., death, voluntary termination)
- **The monthly APTC amount (included in Part III Column C) is the monthly amount of payments that were made to the insurance company to pay for all or part of the premiums for the tax filer’s coverage. The FFEs will enter “0” in this column if no APTC payments were made.

11.4 How Issuers Should Answer Enrollee Questions About Form 1095-A

Issuers may hear from enrollees who have concerns about their Form 1095-A. The Form 1095-A is a record of the prior year’s enrollment with the issuer, CMS expects that issuers should be able to answer most questions individuals may have. This includes verifying enrollment dates, APTC amounts applied, non-EHB portions of premiums, etc. Enrollees may call with basic questions about the Form, tax filing, or concerns about the data on the Form 1095-A. Responses to basic enrollee questions will depend on the type of issue, and may include:

- Addressing the enrollee’s question directly
- Directing enrollee to call the IRS

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- Directing the enrollee to call the appropriate FFEs or State-Based Exchanges (SBEs)

11.4.1 Basic Form 1095-A Questions Issuers May Answer

- What is this form I received?
- What is Form 1095-A?
- Where can I find more information or instructions?
- Why didn't I receive my Form for catastrophic plans, non-Exchange plans, and dental plans?
- Where can I find my Form 1095-A online?

11.4.2 Enrollee Questions to Be Directed to the IRS or the Tax Filer's Tax Preparer

- Do I qualify for the PTC?
- What are the requirements for the individual shared responsibility provision through 2018?
- How do I report healthcare coverage on my income tax return?
- Will IRS verify that enrollees had minimum essential coverage (MEC)?
- I received a Form 1095-A. How should I report this on my income tax return?
- Can you help me complete my income tax return?
- How do I use the Form 1095-A to fill out my Form 8962?
- Can I get a copy of the Form 8965 or 8962?
- What happens if I don't file my income tax return?
- I can't file/can't pay my tax liabilities by April 15. What should I do?
- Why did I receive a 12C letter from the IRS?

11.4.3 Enrollee Questions to Be Directed to the Exchange

- Why did I receive a Form 1095-A?
- I never received a Form 1095-A. How can I get the Form or the information I need?
- Where can I find my Form 1095-A on my Marketplace account?
- What do I need to do with this Form 1095-A?
- What does this information on the Form 1095-A mean?
- I think my Form 1095-A may have gone to the wrong address. What should I do?
- Why did I get more than one Form 1095-A?
- The information on my Form 1095-A does not look correct. How can I change it?

In addition to the background provided in the section above, issuers can direct enrollees to find answers to tax questions about Form 1095-A on HealthCare.gov/taxes and/or IRS.gov. If they do not find answers, enrollees should contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

11.5 Form 1095-A Basics for Assisting QHP Enrollees

The following background information can be used when addressing and triaging basic enrollee questions.

Tax filers receive Forms 1095-A if they or a member of their household were enrolled in a QHP through the Exchange for any months in the coverage year, with or without receiving APTC. Forms 1095-A will not be generated for enrollees:

- Enrolled in only a dental or catastrophic plan, (since APTC may not be applied to these types of policies, taxpayers are not eligible to receive APTC, nor can they claim the PTC on their tax return);

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- Enrolled in a plan outside of the Exchange.

Each Form 1095-A is specific to a plan year and is not necessarily comprehensive. Just as some tax households receive multiple W-2s if individuals have multiple jobs, some tax filers will get multiple Form 1095-A as if they were covered under different plans or made changes to their tax household during the year. There are several reasons why a tax filer may receive more than one Form 1095-A:

- If members of the household were enrolled in more than one health plan through the Exchanges;
- If an Exchange Policy ID changed because an enrollee reported a change to the Exchange that caused a new policy to be issued such as removing the original subscriber;
- If enrollees chose a new plan during the year, (e.g., because of a special enrollment period (SEP) associated with marriage, adoption, birth, change in Indian status); and
- If there are more than five individuals covered by a policy:
 - The additional Forms 1095-A will continue Part II information.
 - Parts I and III will be left blank. The extra pages will come in the same envelope, all together.

Enrollees need the information on Form 1095-A to complete IRS Form 8962, which they must file with their tax return if they want to claim PTC or if they received premium assistance through APTC. Form 1095-A lists the individuals who were enrolled in a QHP, the QHP premium, and any APTC that was paid on the enrollee's behalf to the issuer. It is important to note that premium amounts reported on Forms 1095-A are not the amount that enrollees are used to seeing on their monthly insurance bill, because they are:

- Reduced for premiums allocated to benefits exceeding EHBs;
- Increased by premiums for a stand-alone dental plan (QDP) allocated to pediatric dental benefits; and
- Not reduced for applied APTC

11.5.1 Form 1095-A Reprints and Corrections

If enrollees want another copy of their Form 1095-A, issuers should direct them to log into their online Exchange account and print their form in the "Tax Forms" section. If enrollees do not have online accounts, they can create one to view and print their Form 1095-A. Alternatively, reprint requests can be made to the Marketplace Call Center and enrollees should expect to receive a hard copy of their Form 1095-A in the mail within one to two weeks.

Despite CMS's data quality efforts, in some cases, FFE information about enrollees may be incorrect. Enrollees can request corrections be made to their Form 1095-A information in writing or by phone but are strongly encouraged to make requests by calling the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).

When enrollees request a change of address or a change in coverage information via the Marketplace Call Center, a Health Insurance Casework System (HICS) case is opened and placed in the corrections casework queue. Corrections caseworkers then process the change, the FFEs database is updated, and the HICS case is closed. Finally, the FFEs send issuers IPA's and 834 transactions accordingly.

- **Issuer Assistance:** If enrollees reach out to their issuers first, and have questions about policy start or end date, covered individual start or end date, or APTC or premium amount, issuers should check issuer records against the Form 1095-A (as reported by the enrollee) and enrollee's understanding of the correct data. If issuer records match information on Form 1095-A (as reported by the enrollee) but not the enrollee's records of coverage, direct the enrollee to the

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Marketplace Call Center if they have additional questions.

As outlined in more detail below, the FFEs evaluate enrollees' assertions that information on Forms 1095-A is incorrect, updates incorrect data, and generates initial, Corrected Forms 1095-A, or Voided Forms 1095-A) accordingly.

When appropriate, CMS leverages a recurring bi-monthly corrections process to update the FFEs database and generate Forms 1095-A and notices. At the conclusion of each cycle, initial and Corrected Forms 1095-A and Voided Forms 1095-A are generated, mailed to tax filers, and sent to the IRS to ensure all parties have accurate information.

Enrollees who want to request updates to their Forms 1095-A should call the Marketplace Call Center by early March to maximize the likelihood that they get an update before the tax filing deadline.

11.5.2 Form 1095-A Corrections Process: Additional Information

The CMS Marketplace Call Center representatives will leverage available resources (e.g., standard operating procedures [SOPs], frequently asked questions [FAQs], scripts) to try and address enrollees' Form 1095-A concerns.

Research: If enrollees' concerns are not resolved, Marketplace Call Center representatives will triage the case accordingly and CMS will conduct research to evaluate the information in question. CMS research process includes:

- Review of FFEs data;
- Review of the enrollee's Form 1095-A data (via MIDAS 1095-A extract);
- Outreach to issuers via HICS email/phone to confirm if issuers' records match data on Form 1095-A, as needed; and
- Outreach to enrollees to obtain additional information, as needed.

Enrollee Outreach: If research concludes that an enrollee's Form 1095-A is derived from incorrect data (i.e., data on Form 1095-A does not match what the enrollment record should be, and the enrollee request for a corrected form is approved), Form 1095-A Corrections caseworkers call enrollees to tell them their request was approved and close the HICS case. The updated data is submitted to the next Form 1095-A Corrections cycle, and Forms 1095-A are generated, posted to the Marketplace account, and mailed to enrollees.

If research concludes that data on an enrollee's Form 1095-A is correct (i.e., data on Form 1095-A matches FFEs data sources, and enrollees' requests are denied), corrections caseworkers call enrollees to tell them their request was denied. If enrollees are satisfied with CMS's decision, the HICS case is closed and a denial letter is sent to the enrollee for their records. The enrollee should file their taxes with their existing Form 1095-A.

If an enrollee is not satisfied with CMS's decision, he or she may request that the case be reconsidered. In such cases, CMS Regional Office caseworkers review the corrections caseworker's decision, including collection of additional input from the enrollee and/or issuer as needed, and make a recommendation to the corrections caseworker to approve the enrollees' request or uphold the denial. The corrections caseworker will again follow up with the enrollee by phone regarding approval or denial of the reevaluated decision and will close the HICS case.

Correction Cycle Fallout: In some cases, Form 1095-A files fail to generate successfully (i.e., "fallout")

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due to errors. CMS conducts research to resolve errors and resubmits the Form 1095-A file back into the next correction cycle or manually generates the form (if automatic generation is not possible).

- This process adds 2–4 weeks to the average case resolution time. Some Form 1095-A fallout will lead to scenarios where the Form 1095-A's are not available in enrollees' online account.

Summary: After requesting a correction, enrollees can expect:

- To get a phone call from a corrections caseworker within two weeks;
- To receive a hard copy of their Form 1095-A in the mail within approximately 2–4 weeks (add an additional 2–4 weeks for “fallout” when applicable); and
- To receive a denial notice in the mail within:
 - Approximately 2–3 weeks for cases denied without escalation; or
 - Approximately five weeks for cases denied and escalated for a second review.

CMS is required to carry out this process and furnish accurate Forms 1095-A for enrollees for up to seven years.

11.6 Impact of Prior Year Appeals

Prior year eligibility appeal decisions from the Exchange Appeals Center present a specific challenge to producing an accurate Form 1095-A for enrollees (or appellants) who receive an appeal decision in their favor and choose to have their decision implemented retroactively.

Appeal decisions implemented after March of the subsequent year (once data reconciliation and IC834 transaction have concluded for prior year coverage) require additional handling and care to ensure that individuals receive an accurate Form 1095-A.

The information below is updated from a previously released Section 8.1 of Bulletin #17 – Effectuation Eligibility Appeal Decisions and Related Enrollments in the Federally-Facilitated Exchanges (FFEs).

11.6.1 Steps to Follow for Prior Year Appeal Adjudications

1. Upon receipt of a HICS case instructing an issuer to implement a prior year appeal decision, the issuer should follow the directions in the HICS case narrative.
2. Once an issuer has followed the directions in the HICS case narrative related to a retroactive appeals decision, it should submit these enrollment changes via the ER&R Enrollment Dispute Process (see Section 9). These updates will also be noted on the next Pre-Audit file released for the year that the update was made in the FFEs. Please refer to the Reconciliation External Calendar for delivery dates of each Pre-Audit file. It can be located at <https://zone.cms.gov/document/enrollment-data-reconciliation>.

FFE updates accepted via the ER&R Dispute process will automatically trigger Corrected or Voided Forms 1095-A for retroactive Appeals determinations.

12. ELIGIBILITY CHANGES FOR THE DUALY ENROLLED AND DECEASED

Exchange enrollees aren't eligible for financial assistance such as advance payments of premium tax credit (APTC) and cost-sharing reduction (CSR) if they are eligible for or enrolled in other minimum essential coverage (MEC), such as coverage provided by Medicare Part A or Part C (Medicare Advantage), certain qualifying Medicaid or Children's Health Insurance Program (CHIP) coverage, or certain coverage provided by an employer plan. Enrollees who don't report eligibility for or enrollment in other coverage to the Exchange are at risk of having to repay APTC when they file their annual federal income tax return and reconcile APTC. While an issuer should not end financial assistance if it believes the enrollee is eligible for other MEC, the issuer is encouraged to reach out to the enrollee suspected of being eligible for MEC to urge the enrollee to report the eligibility for other coverage to the Exchange so that the enrollee's eligibility can be re-determined, and financial assistance removed prospectively, if appropriate.

Similarly, if an issuer receives information that an enrollee is deceased, the issuer should direct the qualified individual (QI) or representative to report the death of the enrollee through their HealthCare.gov account or by calling the Marketplace Call Center and following the steps in Section 8.2.1.

A QI is only eligible for financial assistance on one Exchange enrollment. When an enrollee changes from one QHP enrollment to another QHP on the Exchange, such as during a special enrollment period (SEP), the Exchange automatically terminates the enrollee's coverage under the first QHP, if the enrollee uses their existing Exchange account. If an enrollee or an assister or Agent or Broker (A/B) creates a new enrollment without using the existing account, a dual Exchange enrollment can be created. Other dual enrollments are created inadvertently when a dependent on one application/enrollment creates a new application and enrollment without the original application contact ending coverage for the enrollee on the initial policy, or when parents in separate households enroll the same child on each parent's policy. Because these dual Exchange enrollments are inadvertent and financial assistance may only be applied to one policy, the Exchange conducts monthly "overlaps clean-ups" that end the overlapping or dual coverage. Issuers can find enrollments cancelled for duplicating other Exchange enrollments by checking to see if the policy is flagged for overlaps on the regularly scheduled monthly pre-audit file.

Issuers should review records flagged with the overlaps indicator on the Pre-Audit file to ensure proper alignment of enrollment records based on the enrollment transactions initiated by the enrollee, which may necessitate termination or cancellation of impacted policies. The flag will be set only the records cancelled or terminated on the Federally-Facilitated Exchanges (FFE) as part of the overlapping enrollment cleanup—the subsequent records that led to the overlap are not flagged in the file. The overlapping or duplicate coverage may be with a different issuer, which will be conveyed by the overlap's indicator value.

Issuers who observe dual Exchange enrollment because it is the issuer of both policies may use reconciliation to eliminate the overlap or encourage the enrollee to contact the Exchange.

12.1 Periodic Data Matching

Enrollees who are eligible for or are enrolled in MEC Medicaid, CHIP, or Medicare are ineligible for APTC/CSR to help pay for Exchange plan premium and covered services.

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The FFEs proactively check trusted data sources to re-determine eligibility for financial assistance for those found dually enrolled in Exchange coverage and other MEC and to determine if an enrollee has become deceased during a plan year. As described at 45 CFR §155.330(d), Periodic Data Matching (PDM) includes the process by which the Exchange⁴³ periodically examines available data sources to determine whether enrollees who are enrolled in Exchange coverage with APTC/CSR are concurrently enrolled in MEC Medicaid or CHIP⁴⁴ or Medicare Part A or Part C, otherwise known as Medicare Advantage. As described in the Exchange Final Program Integrity Rule⁴⁵, beginning on January 1, 2021, all Exchanges will be required to conduct PDM at least twice per calendar year. State Exchanges that have implemented a fully integrated eligibility system with their respective State Medicaid programs, that have a single eligibility rules engine that uses Modified Adjusted Gross Income (MAGI) to determine eligibility for APTC, CSR, Medicaid, CHIP, and the Basic Health Program (BHP), if a BHP is operating in the service area of the Exchange, will be deemed in compliance with the Medicaid/CHIP PDM requirements and, if applicable, BHP PDM requirements.

12.2 Medicaid/CHIP Periodic Data Matching

The Exchange conducts Medicaid/CHIP PDM at least twice during the coverage year. The Exchange sends an initial warning notice to the application contact of the affected enrollees. The application household contact and/or affected enrollees have 30 days from the date of the notice to respond. The notice instructs them to return to the Exchange by the date listed in the notice to either a) update their application by indicating they are not enrolled in Medicaid or CHIP, if applicable, or b) by ending Exchange coverage with APTC/CSR if they are enrolled in Medicaid or CHIP.

At least 30 days after sending the initial notice, the Exchange sends a second, final notice to the application household contact of affected enrollees who did not take appropriate action by the deadline, informing them that the Exchange will be ending any financial assistance. Exchange coverage for affected enrollees will continue without financial help and they will need to end their Exchange coverage if they no longer wish to be enrolled in that coverage at full cost. If they choose to remain in full-cost Exchange coverage, they should notify their state Medicaid or CHIP agency of their Exchange enrollment; they may no longer be eligible for CHIP. For unaffected household members, Exchange coverage may continue, and the Exchange will redetermine their eligibility for APTC/CSR, if applicable. The issuer will receive notice of these changes through an enrollment transaction, typically sent as a maintenance (M834) transaction that removes financial assistance for the dually enrolled member.

Both notices are mailed and/or posted to the Exchange account of the household contact for the affected individual(s) (depending on communication preference). A sample of the PDM notices can be found at <https://marketplace.cms.gov/applications-and-forms/notices.html>.

An FAQ containing more information on Medicaid/CHIP PDM is available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Medicaid-CHIP-Periodic-Data-Matching-FAQ.pdf>.

⁴³ This includes Federally-Facilitated Exchanges and State-Based Exchanges using the federal eligibility and enrollment platform.

⁴⁴ Most Medicaid is considered MEC; some forms of Medicaid that cover limited benefits, like Medicaid that only covers emergency care, family planning, or pregnancy-related services, are not considered MEC. For more information on what Medicaid programs are considered MEC, visit <https://www.healthcare.gov/medicaid-limited-benefits/>. Most CHIP is considered MEC.

⁴⁵ 84 Fed. Reg. 71674 (Dec. 27, 2019).

12.3 Medicare Periodic Data Matching

The Exchange also periodically examines data sources to determine whether individuals receiving federal financial assistance have been determined eligible for or enrolled in MEC Medicare.⁴⁶ Individuals dually enrolled in MEC Medicare and Exchange coverage are ineligible for financial assistance. When filing their federal income tax return, enrollees may have to pay back all or a portion of the APTC paid on their behalf for months they had both Exchange coverage and MEC Medicare.

Individuals found to be dually enrolled must be notified of the determination pursuant to 45 CFR §155.330(d)-(e) and if the enrollee doesn't respond within 30 days of the date of the notice, the Exchange must take action to end APTC and CSR or Exchange coverage, depending on consumer preference. Medicare PDM notices will include the names of individuals who were found to be dually enrolled in MEC Medicare and Exchange coverage, a recommendation and instructions to end Exchange coverage with APTC/CSR to those dually-enrolled individuals, and where to find contact information to confirm Medicare enrollment or if they have any questions about Medicare. Consumers are asked on their Exchange application if they would prefer to have their coverage ended if they are found dually enrolled in coverage, as opposed to just having their APTC ended.

Currently, if the FFEs identify QHP enrollees as dually enrolled during the PDM process and the enrollee(s) agreed upon enrollment to allow the FFEs to terminate their coverage if they are found to be enrolled in other qualifying coverage, such as MEC Medicaid/CHIP or MEC Medicare (via the FFE termination attestation application question), they will have their Exchange coverage terminated. For enrollees who do not provide consent for their Exchange coverage to be terminated, the FFEs will instead end their APTC/CSR. As outlined in 45 CFR §155.330, the FFEs will send out a notice and enrollees will have 30 days to respond before the FFEs take any action. Also, FFEs will not redetermine eligibility for APTC/CSR for enrollees who voluntarily permit the FFE to end their Exchange coverage if later found to be enrolled in Medicare. Issuers will be informed of necessary changes to enrollee(s)' coverage via the current 834 transaction process and guidance.

12.4 Medicare Anti-Duplication

Under section 1882(d)(3)(A)(i)(I) of the Social Security Act, it is illegal to knowingly sell or issue an Individual Market Exchange Qualified Health Plan (or an individual market policy outside the Exchange) that duplicates⁴⁷ Medicare or Medicaid benefits a beneficiary is entitled to. This prohibition does not apply to a renewal of coverage under the same policy or contract of insurance. This prohibition also does not apply in the SHOP market, or to employer coverage outside of the SHOP market.⁴⁸

An issuer that receives a new Exchange enrollment for a QHP that duplicates coverage for an individual that it has knowledge is entitled to Medicare Part A or enrolled in Medicare Part B should cancel the coverage with Additional Maintenance Resource Code (AMRC) of CANCEL-ANTIDUPLICATION before it is effectuated (binder paid, and coverage has started). QIs not enrolled in Medicare but whose QHP coverage is cancelled by the issuer because they share a policy with a Medicare enrollee will generally be eligible for an SEP. An issuer may not terminate a Medicare beneficiary's policy during the

⁴⁶ Medicare Part A (hospital insurance) and Medicare Part C (Medicare Advantage) are deemed MEC, whereas Medicare Part B (medical insurance) or D (prescription drug coverage) alone are not considered MEC

⁴⁷ See section 1882(d)(3)(A)(iv) of the Social Security Act (SSA) for the definition of "duplicate."

⁴⁸ See section 1882(d)(3)(C) of the SSA.

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plan year if it gains knowledge of the duplication of coverage after effectuation, but must non-renew the coverage effective December 31, if reenrollment would change the policy or contract of insurance (see also Section 3.4.8 on Medicare Enrollment and Non-renewals).

12.5 Deceased Enrollee Periodic Data Matching

The FFEs take action to end coverage for consumers who are both 1) identified as deceased via a periodic data match through the Exchange's trusted data source and 2) enrolled in a QHP through the Exchange in accordance with 45 CFR 155.330. For these consumers, the FFEs terminate their Exchange coverage retroactively, effective as of the date of the consumer's death if it occurred during the coverage year or effective on the start date of their current year coverage if date of death occurred before current coverage started.

In 2019, the Exchange started ending Exchange QHP coverage for consumers who are enrolled in Exchange QHP coverage and who have been identified as deceased through periodic data checks. This is accomplished by matching Exchange enrollment data against the Social Security Administration's (SSA) Death Master File (DMF), which is provided to CMS from SSA on a weekly basis.

After a consumer is identified as both deceased and enrolled in QHP coverage, the Exchange generates a Death PDM initial warning notice, addressed to the decedent's estate (i.e., "to the estate of..."), with instructions for affected consumers. Due to the sensitivity of death information and to protect the Exchange from potential fraudulent activity, notices are only mailed via United States Postal Mail at this time, even if the consumer's stated preference was electronic delivery only. Notices will not be posted to the "My Account" section of the consumer's online Exchange account.

After receiving the Death PDM initial warning notice, consumers are instructed that no action on their part is required if the reported information is correct. However, consumers have 30 days to report that they are not deceased if the Exchange erroneously identified them as deceased due to a data error in the DMF. To report they are not deceased, consumers can call a special outreach hotline established by CMS and leave their contact information. These consumers receive special notice outreach from CMS in order to: 1) confirm that they are not in fact deceased, and 2) provide guidance on how to correct their information with SSA.

For consumers who do not report they are not deceased, after the 30-day window expires, the Exchange takes action to end QHP coverage for Exchange enrollees who were identified as deceased. QHP coverage is terminated retroactively to the reported date of death as received from SSA's DMF. The Exchange will ensure that appropriate actions are taken to make necessary adjustments to APTC, CSR, premiums, claims, and user fees, including by instructing Exchange issuers to refund premium payments to the deceased's estate for QHP coverage retroactively terminated due to death.

Due to functionality limitations, the Exchange only undertakes this process for deceased enrollees in single-member applications. CMS is currently exploring IT functionality developments to allow the Exchange to take action and remove deceased enrollees from applications in which multiple members are enrolled.

13. ADDRESSING INDIVIDUAL-REPORTED UNAUTHORIZED ENROLLMENTS & ISSUER-REPORTED FRAUDULENT ENROLLMENTS

The Federally-Facilitated Exchanges (FFEs) and State-Based Exchanges using the federal platform (SBE-FPs) receive complaints alleging fraud and/or misrepresentations from both individuals and issuers regarding suspect enrollments into Qualified Health Plans (QHP) offered through the FFEs or SBE-FPs. CMS, as administrator of the FFEs and of the federal platform for the SBE-FPs, takes each complaint seriously, and the Center for Consumer Information & Insurance Oversight (CCIIO) works closely with the Center for Program Integrity (CPI) to review and respond to these complaints through two distinct processes. The first process (see Section 13.1) deals with complaints from individuals who call the Marketplace Call Center to report alleged fraud or misconduct by an individual other than the enrollee, resulting in unauthorized enrollments. The second process (see Section 13.2) focuses on information submitted to CMS by issuers whose internal analyses or investigations revealed possible enrollment fraud or the intentional misrepresentation of material facts during the application and enrollment process. Each of these processes is described below.

13.1 Individual Complaints Alleging Unauthorized Enrollments

The Marketplace Call Center receives calls from individuals reporting that they are enrolled in Exchange plans they did not know about or authorize. In many cases, the individuals stated that they only learned they were enrolled in a QHP through the FFEs when they received a communication from the Exchange, an issuer, or the Internal Revenue Service (IRS), which requires that advance payments of the premium tax credit (APTC) be reconciled with annual federal income taxes before refunds can be processed. In some cases, the individuals indicated that they already had other health insurance and did not need or want an Exchange plan.

Regulations at 45 CFR 155.430(b)(1)(iv)(B) and (C) specify that an Exchange issuer may cancel a policy if “[t]he enrollee demonstrates to the Exchange that their enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment. For purposes of this paragraph (b)(1)(iv)(B), misconduct includes the failure to comply with applicable standards under this part, part 156 of this subchapter or other applicable Federal or State requirements as determined by the Exchange,” or if “[t]he enrollee demonstrates to the Exchange that he or she was enrolled in a QHP without their knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.”

13.1.1 Operational Process for Cancelling Unauthorized Enrollments

The process below describes the operational process used to cancel confirmed unauthorized enrollments that was first piloted from February to June 2019. In June 2019, the new process began and now applies to all FFE issuers. CMS may update the operational process from time to time for the efficiency of the Exchange and issuers. Changes to the operational policy would be discussed through regular FFE/issuer communication channels.

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All complaints that are classified as possible Unauthorized Enrollments are sent to issuers through the Health Insurance Casework System (HICS).⁴⁹ The complaints are categorized as Category 2 – Plan and Issuer Concerns with the Subcategory Cancellation/Termination Request or Alleged Unauthorized Enrollment. Issuers should examine the case to determine if CMS’s three unauthorized enrollment criteria are met. If all are true, it would indicate the enrollee might not know about the enrollment. The criteria are:

1. The individual’s premium is covered 100% by APTC or, if not 100%, any portion of the premium that is the responsibility of the enrollee was NOT paid.
2. No claims have been filed for any of the enrollees on the policy. (If the issuer believes the policy was unauthorized by the enrollee, but claims have been submitted, issuers should have their program integrity team or SIU follow the process for submitting a rescission request to CMS as outlined below. This is especially important if the providers are out-of-network substance abuse facilities, sober homes, or laboratories billing for drug testing as these may indicate an enrollment scheme.)
3. The issuer has had no contact from the enrollee about their policy or benefits, including emails and calls to customer service, or the enrollee only contacted the issuer within the 60 days prior to contacting the Exchange to cancel coverage to report they did not know about or consent to the enrollment.

If an issuer finds that all three of the criteria are true, the FFEs will consider this corroboration that the individual was unaware of or did not consent to the enrollment, and a cancellation is appropriate.

If one or more of the criteria are not verified, the policy should not be cancelled, absent further information from the enrollee that demonstrates the elements necessary to support cancellation under the regulations.

All HICS cases must be thoroughly documented per *CFR 156.1010 (g)(2)*. Once the issuer has determined whether or not the policy will be cancelled, that information **must be documented** in HICS by using the “Outcome of Resolution” drop down. The “Outcome of Resolution” choices should be used as follows:

- **Approved cancellation** – Issuer should select the dropdown choice *“Issuer has adjusted its record, in whole or in part, in accord with the request/directive”*
- **Denied cancellation** – Issuers who aren’t able to cancel the policy should choose the dropdown that indicates why the policy cannot be cancelled, i.e., a) the consumer had paid claims, b) the consumer paid premiums, or c) the consumer contacted the plans for reasons other than to cancel their policy. If there are multiple criteria that were not met, issuers may select the option *“Issuer is not permitted to make any requested change(s) according to CMS/issuer policy”*

13.1.1.1 Implementing Cancellations for Unauthorized Enrollments

Issuers are asked to cancel 2019 policies that meet all three criteria by submitting an inbound 834 with a CANCEL-FRD Additional Maintenance Reason Code (AMRC). Once the policy is cancelled in the FFEs, the FFEs recoup any APTC and make adjustments for user fees. Policies for plan years before 2019 must be cancelled via an Enrollment Resolution and Reconciliation (ER&R) dispute, setting “Prior Year – End Date” to equal the start date of the policy.

It is important to submit a CANCEL-FRD AMRC **even if the policy is already terminated for non-**

⁴⁹ Issuers reporting unauthorized enrollments using the Health Insurance Casework System (HICS), should follow this guidance: https://www.regtap.info/uploads/library/ENR_UEFF9_Instructions_5CR_060719.pdf and https://www.regtap.info/uploads/library/ENR_HealthInsuranceCaseworkSystem_UE_062419_5CR_071519.pdf

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payment because many of the individuals had APTC that covered all or some of their premium payments, resulting in Form 1095-As being generated and shared with the IRS for any month(s) of the year in which APTC payments were made. To relieve individuals of tax liabilities for unauthorized enrollments a corrected 1095-A must be created, which can only happen once the policy is cancelled back to the effectuation date.

Finally, as with any HICS case, regulation requires that **the issuer contact the consumer to report the resolution of the case** whether the policy is cancelled or remains in effect.

If issuers have questions about this process, they should email the Marketplace mailbox at MarketplaceIntegrity@cms.hhs.gov.

13.2 Issuers' Requests: Examples of Elements Demonstrating an Appropriate Rescission of QHPs in the Exchanges

13.2.1 Reporting Fraudulent Enrollments

Issuers of individual health insurance coverage,⁵⁰ including QHPs offered through an Exchange, may only rescind such coverage when the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage.

Regulation at 45 CFR §155.430(b)(2)(iii) provides Exchanges the option to require that QHP issuers demonstrate, to the reasonable satisfaction of the Exchange, that the basis for a rescission is appropriate. FFEs require that QHP issuers demonstrate that a rescission is appropriate, using the procedures described below, before rescinding coverage.

QHP issuers wishing to send CMS a rescission request should ask their CMS Account Manager for the most recent version of the Rescission Request Form or find the form at https://www.regtap.info/reg_library_openfile.php?id=2568&type=1. The form should be filled out as completely as possible, encrypted to protect personally identifying information, and sent to the Account Manager with a copy to the Center for Program Integrity's (CPI) mailbox at Marketplaceintegrity@cms.hhs.gov. The CMS Account Manager will review the request for completeness, may request additional information from the issuer, if necessary, to review the submission, and may reject requests that are incomplete or do not meet the bases for a rescission. Complete requests receive additional review from CMS, which aims to respond with a written communication from CPI sent electronically within 30 days. Issuers with pending submissions may contact their CMS Account Managers for a brief update of status. Any Agent or Broker (A/B) associated with fraudulent schemes may have their FFE agreements suspended or terminated.

Issuers with policies approved for rescission must provide 30 days' advance written notice to the subscriber (the subscriber's FFE mailing address may suffice) whose policy is being rescinded as required in 45 CFR 147.128(a). The issuer should use enrollment data alignment to cancel policies approved for rescission using AMRC CANCEL-RESCIND. At the time of publication, cancel reason can only be accomplished using IC834 transactions. ER&R disputes tentatively plans to accept cancel reason codes

⁵⁰ The prohibition on rescissions also applies to group health plans, health insurance issuers offering group health insurance coverage, and health insurance issuers offering individual market coverage outside the Exchanges. See 45 CFR §147.128. However, this document is addressed to individual market QHPs offered through an FFE about what the FFEs may rely on to determine whether a rescission is appropriate.

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beginning in July 2020, with monthly reconciliation also beginning to accept reason codes in late 2020, or early 2021. Issuers should continue to leverage IC834 whenever possible for submitting approved rescissions until those changes are finalized and communicated to issuers. Once properly rescinded, the issuer may reverse claims and refuse additional claims filed for the same rescinded policy. CMS recoups any APTC paid for that period through policy-based payment just as in any other retroactively cancelled policy.

Stakeholders have asked for examples of what information the FFEs would consider in determining whether it is appropriate for an issuer to rescind coverage under a QHP offered through the FFEs.

Although the FFEs are unable to give an exact formula for an approved rescission, the elements listed below are meant to be a guide to QHP issuers in gathering evidence to be submitted to the FFEs to support the appropriateness of any rescission request.

The examples below can serve the purpose of demonstrating to the FFEs under 45 CFR §155.430(b)(2)(iii) indicia of fraud or intentional misrepresentation of material facts. However, comprehensive review of all relevant facts and circumstances will be necessary. Note that these examples do not automatically meet the criteria necessary to permit a rescission, and an issuer will need to provide evidence to substantiate compliance with applicable rules regarding rescissions.

The examples below are not exhaustive and are not a substitute for any regulations or other interpretive guidance.

Demonstrating fraud or intentional misrepresentation of a material fact generally requires showing that the information was false, and intent by the individual (or a person seeking coverage on behalf of the individual) to use false information to obtain coverage.

13.2.1.1 Falsity of Information

The issuer must demonstrate that the enrollee (or a person seeking coverage on behalf of the enrollee) intentionally provided information that was false. The following are examples of information that could be presented to demonstrate the falsity of information presented to the issuer. One of these examples of false information alone may not be sufficient to show intentional wrongdoing, but multiple examples of false information may indicate an intention to defraud:

- A. **False residency address:** Evidence that an enrollee's residency address in the servicearea may not be valid or may not comply with FFE residency rules could include:
 - An address at which the enrollee could not have lived.
 - A single address listed for an unreasonable number of enrollees.
 - An address associated with known fraud in the past.
 - Enrollment pursuant to a "permanent move" special enrollment period (SEP) where the residency address is that of the facility at which the enrollee is receiving treatment on a temporary basis.
 - A statement from the property owner or resident that the enrollee is unknown to the owner or resident and did not live at the address at the time of enrollment nor during the benefit year.
 - A record, made in the normal course of business, which documents the property owner's or resident's claim that the enrollee is unknown to the owner or resident and did not live at the address at the time of enrollment nor during the benefit year.
 - A statement from the enrollee that he or she did not live at the address at the time of enrollment nor during the benefit year.

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- B. **False enrollment:** Evidence indicating that an enrollment may have been submitted without the enrollee's knowledge or consent could include:
- Suspicious patterns of enrollment involving licensed or unlicensed brokers.
 - Suspicious third-party premium payments, such as:
 - Payments from an A/B.
 - Payments for an unreasonable number of enrollees from a source unrelated to the enrollees.
 - Payments that are made with gift cards.
 - Deceased enrollee – The QHP issuer can demonstrate that the enrollee was deceased at the time of enrollment by matching the member name and SSN against the SSA Death Master File (to prevent improper cancellation for enrollees with mistyped SSNs and surviving family members who have inherited the deceased's SSN during a Change in Circumstance [CIC], aka "subscriber inheritance") and that the enrollment was not effectuated retroactively after the enrollee's death.
- C. **Suspicious claims:** Evidence that an enrollee is receiving or has received treatment that corresponds to a known pattern of fraud:
- Since evidence of a specific type of treatment, by itself, seldom (if ever) would be evidence of fraud, an issuer would need to provide evidence (to the satisfaction of the FFEs) that the enrollee was not receiving the billed treatment or was not entitled to the healthcare policy. An example is sober-home schemes in which enrollees are enrolled in plans they are not eligible for by *intentionally* falsifying material information on the applications in order to gain access to policies with generous out-of-network benefits and low out-of-pocket costs.

13.2.1.2 Intent

The issuer must demonstrate that the enrollee (or a person seeking coverage on behalf of the enrollee) intended to provide information that was false. The following are examples of facts that could be presented to demonstrate the intention of the enrollee (or someone acting on the enrollee's behalf) to enroll using false information. One of these examples alone may not be sufficient to show intentional wrongdoing, but multiple examples may indicate an intention to defraud. Examples include:

- A. **Enrollee corroboration.** The issuer communicates with the enrollee in person, by phone or by mail, and the enrollee:
- Corroborates enough indicia of fraud to prove, to the satisfaction of the FFEs, that a rescission would be appropriate; or
 - States that a third-party entered into the enrollment without the enrollee's knowledge and the enrollee does not want the coverage the issuer is seeking to rescind.
- B. **Inability to contact enrollee:** The QHP issuer has made a good faith, but unsuccessful, effort to communicate with the enrollee and:
- The unsuccessful efforts to communicate with the enrollee are documented; and
 - The QHP issuer attempts to communicate with the enrollee using every method of contact (mail, e-mail, phone number) on file for the enrollee.

Note on ***Falsity of Information (B)***: If, within the 30-day notice period prior to the rescission becoming effective, the enrollee states to the QHP issuer that he or she wants the coverage that would be rescinded, and demonstrates to the issuer or attests to the FFEs the validity of the information that supposedly was

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false, forming the basis of the rescission, the QHP issuer must not rescind the coverage.

14. IMPLEMENTATION OF ELIGIBILITY APPEAL DECISIONS AND RELATED ENROLLMENTS IN THE FFEs

14.1 Background

Under 45 CFR Part 155, Subpart F, individuals have the right to appeal Federally-Facilitated Exchanges (FFE) eligibility determinations, including but not limited to:

- Eligibility for advance payments of the premium tax credit (APTC), cost-sharing reduction (CSR), and enrollment in a QHP through the Exchange;
- Eligibility for Medicaid and Children's Health Insurance Program (CHIP) where a state has delegated to the FFEs the authority to make determinations of eligibility for Medicaid and, if applicable, CHIP and delegated authority to the HHS appeals entity to adjudicate appeals of any denial of Medicaid or CHIP eligibility pursuant to 42 CFR §431.10 and 42 CFR §457.1120;
- Eligibility for an enrollment period, including special enrollment periods (SEPs) and plan category limitations (PCL);
- Eligibility for enrollment in a catastrophic plan;
- Failure by the Exchange to provide timely notice of an eligibility determination;
- Eligibility for an exemption from the individual responsibility requirement.

The FFEs provide written notification to applicants and enrollees advising them of their right to appeal when they receive an eligibility determination, including an explanation that an appeal must be requested within 90 days of the date of the notice of the FFE's eligibility determination.⁵¹ In addition, when applicants and enrollees appeal an eligibility redetermination made by the FFEs, they have the right, pursuant to 45 CFR §155.525, to request eligibility pending appeal.

In adjudicating an appeal, the appeals entity for the FFEs, called the HHS appeals entity, reviews the case anew, considering all the information initially used to determine the enrollee's eligibility, as well as all relevant facts and evidence gathered through the appeals process, and establishes whether the contested eligibility determination was correct at the time it was made. If, on appeal, the eligibility determination is found to be incorrect, the individual has the option under 45 CFR §155.545(c) to have the Exchange implement the appeal decision prospectively, on the first day of the month following the date of the appeal decision notice or, retroactively with an effective date the enrollee would have received based on the date the original, incorrect eligibility determination was made, consistent with 45 CFR §155.330(f)(2)(3)(4) or (5), as applicable. In addition, the individual may be granted a 60-day SEP under 45 CFR §155.420, to preserve the enrollment opportunities that the individual would have had, if the eligibility determination had been correct at the time it was made. This SEP begins on the date of the appeal decision and may permit the individual either to enroll in a Qualified Health Plan/Qualified Dental Plan (QHP/QDP), or switch QHPs/QDPs, including, at the individual's option, on a retroactive basis.

⁵¹ Sample eligibility determination notices, which include information about the eligibility appeal process, are available at <https://marketplace.cms.gov/applications-and-forms/notices.html>.

14.2 CMS Role

14.2.1 Notify Issuer to Implement an Appeal Decision

When the contested eligibility determination is found to be incorrect and the appeal decision results in a new eligibility determination, an enrollee can choose to have the appeal decision implemented prospectively or retroactively. The issuer will receive an 834 transaction from the Exchange that communicates the individual's eligibility from the appeal decision, including enrollment effective dates and APTC/CSR eligibility. If an 834 transaction cannot be generated, the issuer will receive a Health Insurance Casework (HICS) case from the HHS appeals entity. The issuer will receive both an 834 transaction and a HICS case when the APTC/CSR eligibility in the 834 transaction needs to be adjusted. All HICS cases will have the sub-category "Eligibility Appeals Related (OHI Use Only)." Refer to the scenarios below for additional information.

If the contested eligibility determination is found to be correct and the appeal decision upholds the Exchange's eligibility determination, the issuer will not receive any communication from the Exchange unless the enrollee requested eligibility pending appeal. Refer to the Section 14.2.2 for more information.

14.2.2 Notify Issuer to Implement a Request for Eligibility Pending Appeal

The HHS appeals entity will create a HICS case to notify the issuer when an individual elects to keep their level of eligibility prior to the contested eligibility determination while the appeal is pending. The HICS case will include instructions to the issuer about the level of eligibility to maintain for the particular individual or individuals. All such cases will be recorded in the "Plan and Issuer Concerns" category and "Eligibility Appeals Related (OHI Use Only)" subcategory and will include an entry of "No" in the HICS field labelled, "Appeals Decision Made." The case narrative field in the HICS case will begin with "<Consumer name(s)> was granted pended eligibility during their appeal. The issuer is to update its internal systems to reflect the eligibility and date(s) listed below. Once updates are completed, the issuer is to confirm these actions in the HICS Case "Resolution" tab. The issuer should also use Enrollment Data Alignment to have the pended eligibility and/or appeal eligibility outlined in this HICS case reflected in the FFE enrollment record."

In certain cases, enrollees who requested eligibility pending appeal may only require a continuation of eligibility for a segment of time, because, after a reduction in or loss of APTC/CSR eligibility, they were able to reinstate their eligibility. For example, an enrollee received APTC/CSR in the prior year and loses their APTC/CSR eligibility effective January 1; then the enrollee updates his application on January 15 and receives APTC/CSR eligibility effective February 1. Such an enrollee may request eligibility pending appeal for the month of January only. When this situation occurs, the HICS case for eligibility pending appeal will include a start date and an end date so the enrollee's subsequent application update (which was effective February 1) is not superseded.

14.2.3 Notify Issuer to Discontinue Eligibility Pending Appeal and Implement the Appeal Decision

At the end of the appeal, which results in either dismissal or an appeal decision, the issuer will receive instructions via a HICS case to discontinue eligibility pending appeal.⁵² These instructions will include the

⁵² The only exception is if the individual did not request eligibility pending appeal, and the appeal is dismissed, or the appeal decision upholds the Exchange's initial eligibility determination

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effective date to end the eligibility that the enrollee received while the appeal was pending, and, if applicable, the coverage effective date to apply the eligibility awarded in the appeal decision. The HICS case will include the HICS case ID # for the previous HICS case that communicated the instructions for eligibility pending appeal, and an entry of “Yes” in the HICS field labelled, “Appeals Decision Made.” The case narrative field in the HICS case will begin with “<Consumer name(s)>’s appeal concluded. The issuer is to update its internal systems to reflect the eligibility/enrollment and date(s) listed in the action below. Once updates are completed, the issuer is to confirm these actions in the HICS Case “Resolution” tab. The issuer should also use Enrollment Data Alignment to have the pended eligibility and/or appeal eligibility outlined in this HICS case reflected in the FFE enrollment record.” The issuer is to update its internal systems to reflect changes to the enrollment and to any APTC/CSR eligibility, as applicable.

Sometimes, an enrollee may independently update their enrollment during the pendency of the appeal. Should that occur, the HICS case containing instructions to discontinue eligibility pending appeal will include further language instructing the issuer to stop eligibility pending appeal the day before the independent enrollment and leave the subsequent, established enrollment unchanged. The HICS case will include the following additional language “The enrollment record reflects that the consumer updated their eligibility and enrollment during the appeal. The consumer’s eligibility and enrollment from the independent update was transmitted to the issuer via 834 and should continue unchanged.”

In limited circumstances, an individual receiving eligibility pending appeal may be permitted to revert to a lower level of coverage if the appeal decision upholds the contested eligibility determination. For example, an individual was eligible for APTC/CSR in the prior year, but his eligibility was redetermined and he was found ineligible for APTC/CSR during the Open Enrollment Period (OEP). The individual enrolls in a Bronze plan because he is ineligible for CSR. He appeals the redetermination and requests eligibility pending appeal. He is granted eligibility pending appeal and enrolls in a Silver plan with APTC/CSR. His appeal decision upholds the Exchange’s eligibility determination. He is eligible for an SEP under 45 CFR §155.420(d)(6)(i) and permitted to enroll in any plan.

14.3 Issuer Role

14.3.1 Enrollment Requirements

Issuers play a critical role in implementing an individual’s appeal decision and, if applicable, the individual’s request for eligibility pending appeal.

- Once an individual is determined eligible for an SEP as a result of the appeal decision, an issuer is responsible for enrolling any individual who selects a plan offered by that issuer through the Exchange and applying any APTC/CSR for which the individual is found eligible upon appeal, as instructed by the FFEs.
- Where the individual is found eligible for and has chosen a retroactive effective date based on the appeal decision, the issuer is responsible for processing or re-processing the individual’s claims incurred during the period of retroactive coverage, collecting premiums from the individual for months of retroactive coverage, and providing the applicable period of time to make payment consistent with Section 7 of the Enrollment Manual.
- In the case of retroactive changes to eligibility for APTC/CSR, the issuer is responsible for refunding or crediting any excess cost-sharing or premiums paid to the enrollee consistent with Section 7 of the Enrollment Manual and applicable state law.
- In the case of an individual’s request for eligibility pending appeal, upon notification from the HHS appeals entity, the issuer must maintain the individual’s enrollment and APTC and, if

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applicable, CSR eligibility level that were in effect prior to the redetermination being appealed. Similarly, at the conclusion of the appeal, upon notification from the HHS appeals entity, the issuer must implement the enrollee's corrected eligibility specified in the appeal decision and, if applicable, discontinue eligibility pending appeal.

- In the case of retroactive changes, the issuer may need to submit the correction to the Enrollment Resolution and Reconciliation (ER&R) contractor in order to ensure the FFE is updated and proper payment from CMS.

14.3.2 HICS Case Resolution Requirements

Upon receipt of a HICS case instructing an issuer to update its enrollment records based on an appeal decision or eligibility pending appeal, the issuer must complete the following actions:

- Update its enrollment records.
- Contact the enrollee to provide the resolution in accordance with the directions in the HICS narrative.
- Close the HICS case with resolution notes acknowledging that its records have been updated and that it contacted the enrollee to provide the resolution in accordance with the HICS case narrative directions.
- Meet the timeliness and notification requirements outlined in 45 CFR §156.1010(d) for all appeals-related HICS cases, whereby an issuer must take action to implement the directions in the HICS case narrative for an appeal-related case no later than 15 days after receipt of the HICS case, and, in cases of expedited appeals (which will be coded as expedited cases in HICS), within 72 hours after receipt of the HICS case.
- Use enrollment data alignment processes,⁵³ including the ER&R dispute process (which includes HICS Direct Disputes), to ensure that the FFE policy record reflects the APTC and CSR amounts granted to the individual and implemented by the issuer pursuant to eligibility pending appeal and, as applicable, the appeal decision that was communicated via HICS. This is necessary for the accuracy of the taxpayer's 1095-A as well as issuer policy-based payment.
 - If the update requires a retroactive adjustment or adjustment to financials, the issuer must update their next RCNI File and submit the HICS case to the ER&R contractor using the HICS Direct Dispute process to ensure the FFE policy is updated correctly.

Issuers must follow regulatory guidelines for communication with enrollees and are encouraged to adopt the HICS case best practices. Recommended language to include in the issuer resolution notes is provided below:

“We updated our internal systems on [insert date of the update] to reflect changes to [Enrollee Name]’s enrollment and to any APTC/CSR eligibility.” [Include the following inserts, as applicable, to the particular case.]

- Enrollment effective date: [Insert effective date].
- Monthly amount of APTC and effective date: [Insert APTC amount and effective date].
- CSR level and effective date: [Insert CSR level and effective date].
- Enrollment termination date: [Insert effective date of disenrollment].
- Monthly amount of APTC and end date: [Insert APTC amount and end date].

⁵³ The enrollment data alignment process is the process that FFEs use to ensure the accuracy and completeness of the information transmitted and to maintain consistent information between issuers and the FFEs. More information about this process is available in Section 10 of the Enrollment Manual.

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- CSR level and end date: [Insert CSR level and end date].

14.4 Appeal Decision Scenarios

Exhibit 29: Appeal Decision Scenarios

Appeals Outcome	Enrollment Actions
Scenario #1. The individual is not enrolled in a QHP. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect and the individual is eligible for APTC/CSR. The individual opts to have the decision implemented prospectively.	<ul style="list-style-type: none"> • The issuer receives an 834 enrollment transaction or HICS case with the individual's plan selection, APTC/CSR eligibility, and prospective effective date. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange.
Scenario #2. The individual is not enrolled in a QHP. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and the individual is eligible for APTC/CSR. The individual opts to have the decision implemented retroactively.	<ul style="list-style-type: none"> • The issuer receives an 834 enrollment transaction or HICS case with the individual's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer processes the individual's enrollment, collects payment necessary to effectuate coverage retroactively, and processes claims submitted by the enrollee or the enrollee's care providers for services furnished on or after the retroactive enrollment effective date. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.
Scenario #3. The individual was enrolled in a QHP with APTC/CSR, but her coverage was terminated due to non-payment because she lost APTC/CSR eligibility and did not make full payments. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and the individual is eligible for APTC/CSR. The individual opts to have the decision implemented retroactively, and where the individual wants to reenroll in the same coverage that was terminated, the prior termination for non-payment is considered erroneous and the issuer is directed to reinstate enrollment into the prior plan.	<ul style="list-style-type: none"> • The issuer receives an 834 enrollment transaction or HICS case with the individual's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer collects premiums in accordance with 45 CFR 155.400(e), and reenrolls the individual, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of the higher level of CSR (if applicable), and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.

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Appeals Outcome	Enrollment Actions
<p>Scenario #4. The individual is enrolled in a QHP with APTC/CSR. The individual receives an appeal decision finding that the contested determination of the amount of APTC/CSR for which the individual is eligible is incorrect, and that the enrollee should have been determined eligible for a different amount of APTC/CSR. The enrollee opts to have the decision applied retroactively in the same QHP.</p>	<ul style="list-style-type: none"> • The issuer receives an 834 enrollment transaction or HICS case with the enrollee's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer processes the adjustments to the enrollee's enrollment, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of the higher level of CSR (if applicable), and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.
<p>Scenario #5. The individual is enrolled in a QHP without APTC/CSR. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and that the enrollee should have been determined eligible for APTC/CSR. The enrollee opts to enroll retroactively in a different QHP offered by the same issuer.</p>	<ul style="list-style-type: none"> • The issuer receives an 834 enrollment transaction or HICS case for the gaining QHP with the enrollee's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer receives an 834 termination transaction for the former QHP with a retroactive termination effective date. • The issuer reprocesses any claims submitted for services furnished to the enrollee, reversing the claims from the former QHP and processing them with the enrollee's corrected CSR level under the gaining QHP. This should be done as if the claims had initially been submitted to the gaining QHP. CMS also encourages the issuer to apply any out-of-pocket costs incurred under the former QHP toward the gaining QHP deductible and maximum out-of-pocket costs to the extent such incurred amounts exceed out-of-pocket costs that would have been incurred under the gaining QHP. • The issuer collects from the enrollee any premiums owed or refunds or credits to the enrollee any excess premiums or cost-sharing paid, in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.

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Appeals Outcome	Enrollment Actions
<p>Scenario #6. The individual is enrolled in a QHP without APTC/CSR. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and that the enrollee should have been determined eligible for APTC/CSR. The enrollee opts to enroll retroactively in a different QHP offered by a different issuer.</p>	<ul style="list-style-type: none"> • The gaining issuer receives an 834 enrollment transaction or HICS case with the individual's plan selection, APTC/CSR eligibility, and retroactive effective date for the gaining QHP. • The former issuer receives an 834 termination transaction with a retroactive termination effective date for the former QHP. • The former issuer terminates the enrollee's coverage, refunds premiums, and reverses claims payments, in accordance with applicable state law. • The gaining issuer collects premiums for all months of coverage in accordance with 45 CFR §155.400(e), effectuates coverage, and processes claims submitted by the enrollee, or the care providers, for services furnished on or after the retroactive enrollment effective date, accounting for the application of APTC/CSR. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.
<p>Scenario #7. The individual is enrolled in a QHP without APTC/CSR. The individual receives an appeal decision finding that the contested determination of ineligibility for APTC/CSR is incorrect, and that the enrollee should have been determined eligible for APTC/CSR. The enrollee opts to have the adjusted APTC/CSR amounts applied retroactively to the current QHP, and to enroll prospectively in a different QHP offered by the same issuer.</p>	<ul style="list-style-type: none"> • The issuer receives an 834 enrollment transaction or HICS case for the gaining QHP with the individual's plan selection, APTC/CSR eligibility, and effective date. • The issuer receives an 834 termination transaction for the former QHP with a termination effective date. • If necessary, the issuer receives a HICS case adjusting APTC/CSR for the former QHP because the enrollee opted to have the corrected APTC/CSR amounts applied retroactively to the former QHP. • The former QHP refunds or credits to the enrollee any excess premiums paid, accounting for the application of APTC, reprocesses claims with the enrollee's corrected CSR level, and refunds to the enrollee any excess cost-sharing paid, in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.

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Appeals Outcome	Enrollment Actions
<p>Scenario #8. The individual is enrolled in a QHP with receives an appeal decision finding that the contested determination of the amount of APTC/CSR for which the individual is eligible is incorrect, and that the enrollee should have been determined eligible for a different amount/level of APTC/CSR. The enrollee opts to have the revised APTC/CSR amounts applied retroactively to the current QHP, and to enroll prospectively in a different QHP offered by a different issuer.</p>	<ul style="list-style-type: none"> • The gaining issuer receives an 834 enrollment transaction or HICS case with the individual's plan selection, APTC/CSR eligibility, and effective date for the gaining QHP. • The former issuer receives an 834 termination transaction with a termination effective date for the former QHP. • If necessary, the issuer receives a HICS case adjusting APTC/CSR for the former QHP because the enrollee opted to have the corrected APTC/CSR amounts applied retroactively to the former QHP. • The former issuer terminates the enrollee's enrollment, refunds premiums, and reverses claims payments, in accordance with applicable state law. • The gaining issuer collects premiums for all months of coverage in accordance with 45 CFR §155.400(e), effectuates coverage, and processes claims submitted by the enrollee, or the enrollee's care providers, for services furnished on or after the retroactive enrollment effective date, accounting for the application of APTC/CSR. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.
<p>Scenario #9. The individual is enrolled in a QHP with APTC/CSR. The individual receives an appeal decision finding that the contested determination of eligibility for APTC/CSR is incorrect, and that the enrollee should not have been determined eligible for a QHP with APTC/CSR. The enrollee opts to terminate their QHP coverage retroactively.</p>	<ul style="list-style-type: none"> • The issuer receives a HICS case with a retroactive termination effective date. • Upon receiving the HICS case, the issuer terminates the enrollee's QHP coverage. • The issuer reverses claims payments and refunds any premiums and cost-sharing paid by the enrollee in accordance with applicable state law. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.

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Appeals Outcome	Enrollment Actions
<p>Scenario #10. The individual is enrolled in a QHP with APTC/CSR. The enrollee reports a life change (ESC-MEC [minimum essential coverage] eligibility that does not offer family coverage) and all application members' QHP enrollment is terminated. The enrollee is contesting that his termination date is incorrect and that the remaining members on the application should remain covered. The enrollee receives an appeal decision finding that the contested eligibility determination was incorrect. The enrollee opts to reinstate coverage for all members but himself on the application and retroactively terminate his QHP on the date initially requested.</p>	<ul style="list-style-type: none"> • The issuer receives an 834 enrollment transaction or HICS case (for all members) with the enrollee's plan selection, APTC/CSR eligibility, and retroactive effective date. • The issuer receives an 834 enrollment transaction that terminates the member gaining ESC-MEC while updating enrollment for the remaining members with the plan selection, APTC/CSR eligibility, and effective date. • The issuer processes the adjustments to the enrollee's enrollment, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of the higher level of CSR, and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.
<p>Scenario #11. The individual is enrolled in a QHP with APTC/CSR. The enrollee reports a life change and is found ineligible for APTC/CSR. The enrollee is contesting the redetermination that she is not eligible for APTC/CSR and chooses to continue receiving APTC/CSR during her appeal. Then, the enrollee receives an appeal decision finding that the contested eligibility determination was correct upholding the Exchange's eligibility determination.</p>	<ul style="list-style-type: none"> • The issuer receives a HICS case for eligibility pending appeal with the effective date and APTC/CSR eligibility. The issuer must apply this eligibility while the appeal is pending. • The issuer processes the APTC/CSR eligibility and effective date to the enrollee's enrollment, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of CSR, and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual. • Once the appeal is decided, the issuer receives a HICS case with an effective date that ceases the provision of APTC/CSR. • The issuer receives an 834 enrollment transaction with the enrollee's plan selection, APTC/CSR eligibility, and effective date. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.

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Appeals Outcome	Enrollment Actions
<p>Scenario #12. The individual is enrolled in a QHP with APTC/CSR. The enrollee reports a life change and is found ineligible for APTC/CSR. The enrollee is contesting the redetermination that she is not eligible for APTC/CSR and chooses to continue receiving APTC/CSR during her appeal. Then, the enrollee receives an appeal decision finding that the contested eligibility determination was incorrect, overturning the Exchange's eligibility determination.</p>	<ul style="list-style-type: none"> • The issuer receives a HICS case for eligibility pending appeal with the effective date and APTC/CSR eligibility. The issuer must apply this eligibility while the appeal is pending. • The issuer processes the APTC/CSR eligibility pending appeal and effective date to the enrollee's enrollment, refunds or credits to the enrollee any excess premiums paid, reprocesses claims to account for the application of CSR, and refunds to the enrollee any excess cost-sharing paid in accordance with applicable state law. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual. • Once the appeal is decided, the issuer receives a HICS case with an effective date that ceases the provision of APTC/CSR eligibility pending appeal. • The issuer receives an 834 enrollment transaction with the enrollee's plan selection, APTC/CSR eligibility, and effective date. • The issuer must apply the eligibility submitted by the HHS appeal entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.
<p>Scenario #13. The individual is enrolled in a QHP with APTC/CSR. The enrollee attempts to add a dependent (e.g., birth, adoption) to their application but is unsuccessful due to an Exchange technical error. The enrollee receives an appeal decision awarding an SEP to enroll the dependent. The enrollee opts to enroll the dependent retroactively in the current plan.</p>	<ul style="list-style-type: none"> • The issuer receives an 834 enrollment transaction or HICS case (including the dependent) with the enrollee's plan selection, APTC/CSR eligibility, and effective date. • The issuer processes the adjustments to the enrollee's enrollment, collects premiums, if applicable, for all months of retroactive coverage, and processes claims submitted by the enrollee or the enrollee's care providers for services furnished on or after the retroactive enrollment effective date. • The issuer must apply the eligibility submitted by the HHS appeals entity for the remainder of the plan year unless otherwise directed by the Exchange. • The issuer must submit these enrollment changes via the enrollment data alignment process. More information about this process is available in Section 10.3.3 of the Enrollment Manual.

14.5 Impact of Appeals on Reconciliation

The HHS appeals entity communicates appeal decisions that yield policy level updates to issuers via HICS. Enrollment changes due to appeal decisions implemented before March of the subsequent year should be updated utilizing the IC834 process where possible. This includes effectuating, cancelling, or terminating policies. The IC834 process can also reinstate most policies or coverage spans.

If the IC834 process cannot resolve the HICS case, the issuer should submit the updates on the next RCNI. If the update requires a retroactive adjustment or adjustment to financials, the issuer must submit the HICS case to the ER&R contractor using the HICS Direct Dispute Process in addition to the RCNI

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update to ensure the FFE policy is updated correctly. Please refer to Section 10 of the enrollment manual for additional guidance on submitting updates through the monthly reconciliation process.

There are some situations where current year appeals must be submitted to the ER&R contractor through the dispute process because the monthly reconciliation process is unable to update the FFEs. Please refer to Section 10 of the enrollment manual for guidance on how to submit disputes to update the FFEs' records.

Enrollment changes due to appeal decisions implemented after March of the subsequent year (once data reconciliation and IC834 transaction have concluded for prior year coverage) must be submitted via the ER&R Enrollment Dispute Process (see Section 10.2). These updates will also be noted on the next Pre-Audit file released for the year that the update was made in the FFEs. Please refer to the Reconciliation External Calendar for delivery dates of each Pre-Audit file. It can be located at

<https://zone.cms.gov/document/enrollment-data-reconciliation>.

15. HEALTH INSURANCE CASEWORK SYSTEM

The Health Insurance Casework System (HICS) is the official tracking system for Exchange casework and is used by issuers that participate in the Federally-Facilitated Exchanges (FFEes) and State-Based Exchanges on the Federal Platform (SBE-FPs). The HICS system is the means by which the Marketplace Call Center routes cases to issuers that require investigation and resolution.

HICS is also used to direct an issuer to make changes to enrollment effective and end dates, changes to advance payments of the premium tax credit (APTC) and cost-sharing reduction (CSR) resulting from appeal decisions, and other corrections, when the change via 834 transactions or Pre-Audit Files is not possible.

CMS Caseworkers and Account Managers provide technical assistance through the HICS case to issuers or other CMS staff when needed. In addition, the Office of Hearings and Inquiries (OHI) and Eligibility Appeals Support Contractors (EASC) utilize HICS to communicate appeals decisions to issuers.

15.1 HICS Access

HICS is accessible to approved users via <https://hics.cms.gov>. Users are required to comply with all applicable laws and regulations associated with the use of this U.S. Government computer system. After logging on to the system, users can access the “Issuer User Manual” by selecting “Documentation” on the Casework Tracking Start Page menu. Issuers that need HICS access will now be required to complete and submit applications through EFI. The system enhancements offer new electronic receipt and processing of applications for HICS access that eliminates the burden of completing and retaining paper records and physically moving paper applications through multiple steps of the HICS application process. Issuers should download the updated guidance on how to access HICS from the QHP website (information found on the bottom of the page) at

<https://www.qhpcertification.cms.gov/s/Published%20Guidance%20and%20Regulations>.

For additional questions about HICS access, issuers can contact the HICS Access Resource Mailbox at HICS_Access@cms.hhs.gov. HICS users must comply with the annual recertification requirement when notified and complete annual Computer Based Training.

Issuers are expected to acquire and maintain sufficient access to HICS for their staff and train them to use the system. Having sufficient staff access to HICS will aid with individual responsiveness, potentially avoiding the generation of additional and unnecessary HICS cases. Because HICS contains personally identifiable information and personal health information, issuer compliance with all applicable CMS privacy and security certification and training is required.

15.2 HICS Category Use

For simplicity and administrative ease, issues in HICS are grouped into one of five categories identified below. Every case recorded in HICS must be assigned a category and sub-category. Category 2, designated as Plan and Issuer Concerns, has been established to record cases related to access to benefits and services provided by a QHP only. The term “QHP” includes Consumer Operated and Oriented Plans (CO-OPs), Qualified Dental Plans (QDPs), and Multi-State Plans (MSPs).

Marketplace Call Center cases are concurrently assigned to an issuer and the CMS Lead Caseworker associated with that issuer in the daily casework load. Category 2 cases where QHPs are not identified are

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placed in an unassigned grouping for CMS review based on the consumer's state.

Per [45 CFR 156.1010](#), resolution and consumer notification all have separate regulatory timeliness requirements. Issuers are to resolve Level 1 (urgent) cases within 72 hours of receiving the case and Level 2 (non-urgent) cases within 15 calendar days of receiving the case. Issuers must notify complainants regarding the disposition of the case as soon as possible upon resolution of the case but in no event later than three business days after the case is resolved. Notification may initially be performed verbally, but all cases must be responded to in writing. The verbal notification of the resolution of the cases will satisfy the timely notification requirement. In instances when the initial notification of a case's disposition was verbal, written notification must be provided to the consumer in a timely manner. A resolution summary of the case must be documented in HICS no later than seven business days after resolution of the case. The record must include a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution.

Issuers have the ability to view and search Category 2 cases if the case is assigned to them, unless the case is marked as a "CMS Issue." Only issuers with access for that issuer ID can see their member's cases. For example, Company A is not able to see cases from Company B's customers.

15.3 HICS Casework and Expectations

CMS expects qualified health plan (QHP) and QDP issuers to thoroughly investigate and resolve individual issues received directly from members or reach out to their CMS Lead Caseworker or Account Manager for assistance or additional guidance. Additionally, issuers operating in the Exchange must investigate and resolve individual cases, including complaints, forwarded by CMS via HICS in accordance with the requirements at [45 CFR 156.1010](#). Issuers should check HICS daily and monitor adherence to required resolution timeframes. To avoid delays, issuer staff should have appropriate access to enrollment files without the need for escalation to other internal issuer departments. If a case narrative is unclear, the issuer is expected to contact the individual for additional information prior to referring the case back to CMS.

When reviewing HICS cases, issuers should distinguish between directive cases that require them to act and non-directive individual requests that require review prior to action and/or resolution. For example, an appeal decision sent via HICS from "Case Source: CMS Appeals Contractor" will include a [case narrative](#) and changes that the issuer must effectuate as directed. The issuer must update the Exchange through the enrollment data alignment process (see Section 10). Similarly, if an issuer receives a special enrollment period (SEP) enrollment with an EX code and a corresponding HICS case stating that a specific retroactive coverage effective date should be applied, the issuer should treat that as a CMS directive. In contrast, a case narrative such as "Individual believes that she was terminated in error and desires reinstatement," is a non-directive narrative that requires the issuer to investigate first. The issuer should take action to update the individual's record in accordance with applicable laws and policies and only if supported by evidence the individual provides or the issuer develops. In all cases, the issuer must contact the individual with the resolution of the HICS case.

Infrequently, a HICS case narrative may include directive instructions from CMS that the issuer believes to be inconsistent with law or policy. In this situation, the issuer should work with CMS to resolve the matter, starting with the assigned CMS caseworker. Issuers should not effectuate requests inconsistent with CMS policy and guidance.

In general, issuers are not able to reassign HICS cases. With a recent implementation of the HICS Direct

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Disputes functionality, specific cases may now be routed directly to the Enrollment Resolution and Reconciliation (ER&R) contractor to work. These cases include enrollment blockers (new error code “enrollment blocker”), changes to APTC, changes to total premium amount that cannot be resolved through automated reconciliation, and term no longer eligible (NLE) appeals.

Any cases pending with the ER&R contractor will not count toward the issuer’s 72-hour to 15-day resolution timeline; cases with ER&R are paused until they are returned to the issuer and the clock continues. The clock does not start over because it is the expectation that issuers will resolve the case within the total allotted time allowed per [45 CFR 156.1010](#). The time ER&R contractors are allowed to resolve a HICS Direct Dispute will be similar to disputes submitted via an enrollment dispute form and therefore not counted against the issuer’s resolution timeline.

Issuers must continue to review and resolve individual issues after leaving a service area. Issuers entirely exiting Exchange operations should contact their Account Manager about continued casework expectations.

15.4 HICS Casework Best Practices

CMS expects issuers to always annotate cases with comprehensive notes. As a best practice, issuers should immediately annotate actions taken in HICS. Notes at each stage should include the following:

Initial Issuer Notes:

- Acknowledge Receipt
- Brief issue description, including clarifying details not present in the CMS case narrative
- Find related cases and prevent duplicative work by utilizing the “Find Repeat Case” feature, and record related cases found

Interim Issuer Notes:

- Clearly and concisely summarize each step taken, especially if approaching deadline. Include: actions taken; internal referrals; and/or contact with CMS staff.
- Contact Information:
 - Who: Identity verified, names and relationships/titles
 - When: Dates and times
 - How: Method of contact (Including phone numbers and email addresses)
 - What: Summary of the information received and conveyed

Resolution Issuer Notes and Documentation:

- Resolution notes should be more extensive than brief one-liners like: Contact Made, Issue Resolved, and Unable to Contact
- Pertinent case facts, for example:
 - Issuer records updated and/or external referrals to ER&R or the Marketplace Service Desk (MSD).
 - Enrollment or termination information received electronically from CMS
 - Effective date and termination dates, including prior year effective dates and information as it relates to prior year eligibility appeals effectuation.
 - Payment and billing history
 - Summary of resolution (how the case was resolved)
 - Information about how and when the complainant was notified of the resolution

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How and when Complainant Was Notified of Outcome (Verbal and Written or Written Only)

Uploaded Copies of Correspondence Sent to Individuals and Other Entities:

If the issuer requires assistance, the issuer should contact their CMS caseworker prior to resolving the case. Issuers may choose to establish a critical inquiry unit to resolve difficult cases. In some situations, HICS case notes may be released to requestors under the Freedom of Information Act (FOIA). Therefore, case notes' content and comments should be clear, neutral, and factual.

For additional resources when working HICS cases, CMS has released the following guidance through [REGTAP](#) and frequently publish updated or additional guidance:

HICS Access Update (8/5/19):

https://www.regtap.info/uploads/library/ENR_UpdatedHICSAccess_080519_5CR_080619.pdf

Exchange Issuer Best Practices (2019):

https://www.regtap.info/uploads/library/ENR_2019_HICS_BestPractices_5CR_111918.pdf

Exchange Issuer Best Practices (2020):

https://www.regtap.info/uploads/library/ENR_HICSBestPracticesCorrected_021020_5CR_042120.pdf

HICS Enrollment Related Scenarios (1/14/19):

https://www.regtap.info/uploads/library/ENR_HICS_EnrollmentWorkload_5CR_011519.pdf

HICS Direct Dispute Enrollment Q&A (7/31/17):

https://www.regtap.info/uploads/library/ENR_HICSDirectDisputeEnrollmentQAs_5CR_092517.pdf

Handling Terminations (9/30/19) and HICS to Change Termination Date (8/5/19):

https://www.regtap.info/uploads/library/ENR_IssuerRefresherOnFFMTerminations_093019_5CR_100119.pdf

https://www.regtap.info/uploads/library/ENR_HICStoChangeTerminationDate_080519_5CR_080619.pdf

Non-SEP CIC Enrollment Blocker Refresher (2019) and Add a Member Update (2020):

https://www.regtap.info/uploads/library/ENR_EnrollmentBlockerIssuerRefresherTraining_042219_5CR_092519.pdf

https://www.regtap.info/uploads/library/ENR_EnrollmentBlockerProcessUpdate_030920_5CR_031020.pdf

Enrollment Blocker Issuer Refresher Training (4/22/19):

https://www.regtap.info/uploads/library/ENR_EnrollmentBlockerIssuerRefresherTraining_042219_5CR_092519.pdf

Unauthorized Enrollments: Using the Health Insurance Casework System (HICS) (6/24/19):

https://www.regtap.info/uploads/library/ENR_HealthInsuranceCaseworkSystem_UE_062419_5CR_071519.pdf

16. DATA MATCHING ISSUES MONTHLY PROCESSES

16.1 Background

16.1.1 What Are Data Matching Issues or Inconsistencies?

When individuals apply for coverage through the Exchanges, including through HealthCare.gov, the applicable Exchange verifies information that is provided by the individual on their application. Most applicants' information is immediately verified by the Exchange, however, in some cases, the information the applicant provided does not match up immediately with existing records or the applicant may not have provided enough information to match with the Exchange trusted data sources. These types of situations are called data matching issues (DMIs) or inconsistencies.

Examples of DMIs, include:

- Citizenship;
- Immigration status;
- Annual Household Income;
- Access to or enrollment in employer-sponsored minimum essential coverage (MEC) or health coverage from another public entity; and
- American Indian/Alaska Native status.

16.1.2 How Does an Enrollee Know if He or She Has an Income DMI?

Enrollees are informed of DMIs in their initial Eligibility Determination Notice. The notice will let them know that they need to verify information on their application. At that time the 90-day timeframe for providing acceptable documentation is started.

NOTE: For citizenship and immigration DMIs, individuals have a 95-day timeframe

Enrollees are also able to view whether they have a DMI in logging into their online Marketplace account under the Eligibility Results page at HealthCare.gov.

Additionally, enrollees receive a series of Warning Notices: (separate 30-day, 60-day and 90-day notices, and a reminder phone call approximately 14 days before their deadline), updating them on how much time they have left to resolve their DMI.

NOTE: Enrollees may also receive emails or texts from the Marketplace if an individual selected email or text as their preferred form of communication.

16.2 Exchange DMIs Issuer Outreach Files Delivery Processes and Impact to Enrollees

Enrollees must resolve their DMIs by providing additional information to the Exchange within 90 days or (95 days for citizenship or immigration status DMIs). Enrollees with DMIs who are otherwise eligible are able to enroll in coverage through the Exchange during their inconsistency period.

If sufficient documentation is received during the inconsistency period to resolve a DMI the Exchange finalizes the eligibility determination. If they do not resolve the DMIs, individuals with citizenship or

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immigration status DMIs may lose eligibility for coverage through the Exchange and enrollees with other DMIs may undergo a loss or adjustment of their advance payments of the premium tax credit (APTC) and/or cost-sharing reduction (CSR) that could impact their monthly healthcare expenses.

In most situations where one member of an enrollment group is determined not to be a qualified individual (QI), the members of the enrollment group who remain eligible for enrollment through the Exchange would constitute an enrollment group that can be accommodated by the existing Exchange coverage. For example, if two parents and two children are in an enrollment group and one parent loses eligibility for enrollment through the Exchange, the remaining three family members could still constitute a valid enrollment group. If the remaining members of the enrollment group are still eligible for enrollment through the Exchange, and for APTC or CSR, if applicable, they may be able to continue their enrollment through the Exchange, along with their APTC or CSR.

Where the individual who is determined not to be a QI is also the subscriber of the QHP and has their coverage terminated, and the remaining members of the enrollment group reenroll in coverage with the same issuer through the Exchange, the issuer is expected to apply any amounts previously paid toward deductibles and out-of-pocket limits toward the coverage of the remaining members of the enrollment group. Where the enrollee who is determined not to be a QI is not the subscriber of the QHP, and the QHP allows for removal of that dependent as an amendment to the policy, the issuer must apply any amounts previously paid toward deductibles and out-of-pocket limits toward the continuing coverage of the remaining members of the enrollment group.

In some situations, the removal of one or more members from an enrollment group results in a remaining group of enrollees that does not constitute a valid enrollment group based on the issuer's business rules. For example, some issuers may not cover two children without an adult on a single-family policy. If the removal of the individual who was determined ineligible for enrollment through the Exchange results in the remaining eligible members of the enrollment group being unable to continue their enrollment in their same QHP, they will receive a special enrollment period (SEP) to enroll in a QHP through the Exchange.

16.2.1 DMIs Outreach Schedule and Process

- A. During the inconsistency period, issuers are encouraged to conduct outreach to enrollees who have unresolved DMIs. The Exchange will process outreach file transaction data that identifies enrollees with unresolved DMIs. The outreach file represents enrollments for individuals who may experience a change in eligibility for financial assistance or Exchange enrollment unless they successfully resolve their DMI. The Exchange sends the outreach files to issuers via Electronic File Transfer (EFT) code DATAM to give issuers an opportunity to conduct optional outreach to these enrollees. Enrollees who experience an adjustment in eligibility to be enrolled in a Qualified Health Plan (QHP) or for financial assistance; loss or adjustment of APTC and CSR, due to an unresolved DMI, will be indicated on the 834 transaction files to the issuer. As such, issuers will be able to identify if a policy is being modified by the origin code populated on the M834 transaction.
- B. An enrollee who loses eligibility for enrollment through the Exchange due to a DMI will be directed to the issuer to pursue coverage outside the Exchange, if desired by the enrollee. The enrollee will not receive any APTC or CSR for any coverage outside the Exchange, however; the enrollee in these scenarios will generally be eligible for an SEP based on a loss of coverage, if applicable, or change in eligibility for APTC and/or CSR. The issuer is expected to work with the enrollee to avoid gaps in coverage and is encouraged to apply any amounts paid toward

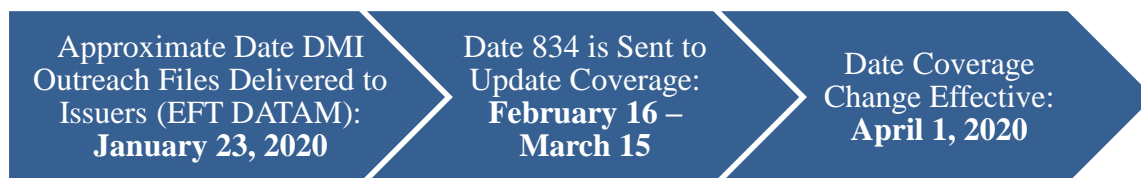
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deductibles and out-of-pocket limits toward the enrollee's coverage outside the Exchange, if such coverage is under a different policy. To the extent the coverage continues uninterrupted outside the Exchange, any amounts paid toward deductibles and out-of-pocket limits would continue uninterrupted, as well.

16.2.2 Exchange DMI File Delivery Schedule

As shown in **Exhibit 30**, DMI Outreach files are delivered to issuers approximately the third week of each month. The related 834 transaction information within the DMI Outreach files identifies consumers with unresolved DMIs approximately 4–7 weeks away from the file date, allowing issuers this window of time to conduct optional consumer outreach.

Exhibit 30: Example Delivery and Transaction Schedule



Issuers are advised not to update their systems with the information contained in the DMI outreach file (sent EFT DATAM). 834 transactions from the Exchange will be sent to issuers to adjust the coverage of enrollment groups impacted. When the FFEs cannot resolve a DMI, resulting in an enrollee being determined not eligible for coverage through the Exchange, an 834 termination transaction is sent from the FFEs notifying the issuer of the termination of the enrollee's enrollment through the Exchange and termination of eligibility for APTC and CSR, if applicable.

16.3 Late Submission of Documentation for DMIs

Enrollees whose Marketplace enrollment status and eligibility for APTC and/or CSR, if applicable, are adjusted or terminated due to their failure to submit sufficient data matching documentation, are provided with an opportunity to reenroll in individual market coverage through the FFEs outside of the Open Enrollment Period (OEP) by producing sufficient documentation to resolve the DMI. In accordance with 45 CFR §155.420(d)(13), the FFEs provide a 60-day SEP for an enrollee described above: 1) who submits the requested supporting documentation to the FFEs; 2) for whom the verification sources are able to establish information based on the trusted electronic data sources (EDSs) or using the sufficient documentation submitted, to resolve the DMI; and 3) who is determined eligible for enrollment in a QHP through the Exchange.

Under the SEP, the individual is able to select new individual coverage through the Exchange. The individual described above, who submits sufficient documentation to resolve their DMI, may request a retroactive effective date to avoid potential gaps in coverage. The retroactive effective date of Exchange enrollment, and APTC and CSR, if applicable, is the day after the effective date of the termination from previous coverage. Alternatively, under 45 CFR §155.420(b)(2)(iii), the individual may also request a prospective effective date of enrollment in the Exchange, for the first of the month following plan

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selection. The appropriate retroactive effective date of coverage will be appropriately communicated to issuers through Health Insurance Casework System (HICS), if necessary.

Enrollees who have their eligibility updated due to certain DMIs (for example, annual household income) may experience an adjustment to their eligibility for insurance affordability programs but will remain eligible. The QIs will continue to be enrolled in coverage through the Exchange with their updated eligibility determination applied. Such enrollees may return to the Marketplace and log into their online account to report a change in information that will update their eligibility. The reported changes may result in an updated eligibility determination and may qualify the enrollee for an SEP to make coverage changes.

17. HEALTH REIMBURSEMENT ARRANGEMENTS

Health Reimbursement Arrangements (HRAs) are a type of account-based group health plan that employers can provide to reimburse employees for their medical care expenses. HRAs do not by themselves comply with certain Patient Protection and Affordable Care Act (PPACA) requirements, such as the prohibition on applying an annual dollar limit to essential health benefits (EHB) and providing coverage for preventative services without cost-sharing for these services. Therefore, after enactment of PPACA, employers could only offer an HRA to individuals who were also enrolled in another group health plan that did comply with these requirements, provided the HRA met other criteria.

However, in 2019, the Departments of the Treasury, Labor, and Health & Human Services jointly published a final rule to permit employers to offer a new type of HRA as of January 1, 2020, called an individual coverage HRA (sometimes referred to as an “ICHRA”), instead of offering a traditional group health plan (hereafter referred to as “the final HRA rule”).⁵⁴ Employees who accept an individual coverage HRA offer, and any covered dependents, must be enrolled in individual health insurance coverage; or Medicare Parts A and B or Part C. Among other qualified medical care expenses, individual coverage HRAs can be used to reimburse premiums for individual health insurance coverage chosen by the employee, promoting employee and employer flexibility, while also maintaining the same tax-favored status as employer contributions towards a traditional group health plan. Employers have the flexibility to pay their portion of payments directly to issuers, or they may reimburse the employee for premiums paid by the employee.

Additionally, the 21st Century Cures Act permits small employers who don't offer group health plan coverage, including an individual coverage HRA, to any of their employees to provide a qualified small employer HRA (QSEHRA) to their eligible employees to help employees pay for medical care expenses. Small employers could provide QSEHRAs for plan years beginning on or after January 1, 2017. An eligible employee can use a QSEHRA to reimburse medical care expenses for him or herself, as well as any covered dependents (if permitted by the employer). To receive reimbursements from a QSEHRA, an employee and any covered dependents must be enrolled in minimum essential coverage (MEC).⁵⁵

17.1 Individual Coverage HRA and QSEHRA Employer Notice Requirements

The final HRA rule generally requires employers to provide employees who are offered an individual coverage HRA with a written notice at least 90 days before the beginning of the individual coverage HRA plan year. However, for employees who become eligible during the plan year, or later than 90 days before the start of the plan year (such as newly hired employees), employers are required to provide this notice no later than the date on which the employees' coverage under the individual coverage HRA can begin.

This employer notice must include key information about the individual coverage HRA, such as:

- The dollar amount of the HRA offer, including the self-only HRA amount available for the plan year;
- The date that coverage under the individual coverage HRA may begin;
- Whether the offer extends to dependents;
- Contact information (including a phone number) for an individual or group that employees may contact for additional information regarding the individual coverage HRA;

⁵⁴ See <https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans>.

⁵⁵ See IRS Notice 2017-67: <https://www.irs.gov/pub/irs-drop/n-17-67.pdf>

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- A statement of the right of the participant to opt out of and waive future reimbursements from the HRA;
- A statement that the HRA requires the employee and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), and a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits;
- A statement that if the employee accepts the HRA, they can't claim a premium tax credit (PTC) for their Exchange coverage or for the Exchange coverage of any dependents who are also covered by the HRA;
- A statement of availability of a special enrollment period (SEP) to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the individual coverage HRA and are not already covered by the individual coverage HRA; and
- A statement that there are different kinds of HRAs (including a QSEHRA) and the HRA being offered is an individual coverage HRA.⁵⁶

Employers that provide QSEHRAs also must provide a notice. Section 9831(d)(4) of the Internal Revenue Code requires an eligible employer who provides a QSEHRA to its eligible employees to provide a written notice to each eligible employee at least 90 days before the beginning of each plan year, or for an employee who is not eligible to participate at the beginning of the plan year, the date on which the employee is first eligible to participate in the QSEHRA. This employer notice must include key information about the QSEHRA, such as:

- The dollar amount of the HRA provided;
- The date that coverage under the QSEHRA may begin;
- Whether the provided QSEHRA extends to dependents;
- A statement that the eligible employee must inform any Marketplace to which the employee applies for APTC of the amount of the provided QSEHRA; and
- A statement that if the eligible employee does not have MEC for any month, the employee may be liable for an individual shared responsibility payment under section 5000A for that month, and reimbursements under the QSEHRA for expenses incurred in the month will be includible in gross income.⁵⁷

17.2 Individual Coverage HRA/QSEHRA SEP

As of January 1, 2020, employees and their dependents who newly gain access to an individual coverage HRA or who are newly provided a QSEHRA may qualify for an SEP to enroll in individual health insurance coverage through or outside of the Marketplace. The triggering event for this SEP is the first day on which coverage for the QI, enrollee, or dependent under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect.

Generally, QIs will need to apply for and enroll in individual health insurance coverage in time for it to take effect by the date that their individual coverage HRA or QSEHRA starts, and the Marketplace will

⁵⁶ For more information on this required notice, see the Individual Coverage HRA Model Notice at <https://www.cms.gov/files/document/hra-model-noticepdf>, and/or 45 CFR 146.123(c)(6), 26 CFR 54.9802-4(c)(6), and 29 CFR 2590.702-2(c)(6) or section 9831(d)(4) of the Internal Revenue Code.

⁵⁷ For more information on this required notice, see Section E of IRS Notice 2017-67: <https://www.irs.gov/pub/irs-drop/n-17-67.pdf>.

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require individuals who receive their employer notice at least 90 days before the first day of their HRA plan year to apply for coverage and select a QHP before their HRA start date. For example, an individual whose individual coverage HRA or QSEHRA starts on July 1st and whose individual coverage HRA or QSEHRA was required to provide them notice at least 90 days ahead of time will need to apply for coverage and select a QHP on or before June 30th. Individuals whose individual coverage HRA or QSEHRA was not required to provide them notice at least 90 days ahead of time will be permitted to select a plan up to 60 days before *or after* their HRA start date but should check with their employer in case they need to enroll sooner to meet their HRA's requirements.

If the individual selects a QHP before the SEP triggering event, which is the first day on which coverage under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect, then, their coverage will take effect on the first day of the month following the date of the SEP triggering event or, if the SEP triggering event is on the first day of a month, on the date of the SEP triggering event. If the plan selection is made on or after the day of the SEP triggering event, coverage will take effect on the first day of the month following plan selection. For more information on the individual coverage HRA/QSEHRA SEP, including relevant 834 codes, see Section 6.

Finally, the final HRA rule preamble clarified that HHS would treat individuals with an individual coverage HRA or QSEHRA with a non-calendar year plan year—that is, with a plan year that starts on a day other than January 1st—as qualifying for an SEP pursuant to existing rules at 45 CFR 155.420(d)(1)(ii) (the non-calendar year plan year SEP). This SEP applies to QIs and dependents enrolled in a group health plan or individual health insurance coverage with a non-calendar year plan year, even if the QI or their dependent has the option to renew the coverage. In addition, while the 21st Century Cures Act section 18001(c) amends the PHS Act definition of the term “group health plan” to exclude a QSEHRA (except for purpose of Part C Title XI of the Social Security Act), the 2021 HHS Notice of Benefit and Payment Parameters final rule amended § 155.420(d)(1)(ii) to codify that individuals and dependents who are provided a QSEHRA with a non-calendar year plan year may qualify for this SEP.⁵⁸

17.3 Individual Coverage HRA/QSEHRA Affordability

Employees and their dependents who are offered an individual coverage HRA are not eligible to receive APTC or PTC if the individual coverage HRA offer is affordable. For plan years beginning in 2020, an individual coverage HRA is considered affordable for an employee (and dependents, if applicable) if the monthly premium of the self-only lowest-cost silver plan (LCSP) available to the employee through the Exchange for the rating area in which the employee resides, minus the monthly self-only amount made available to the employee under the individual coverage HRA, does not exceed 9.78% of 1/12 of the employee's household income.

For employees and their dependents for whom an individual coverage HRA is not affordable, APTC or PTC is allowed if the employee offered the coverage opts out of the individual coverage HRA and the other APTC/PTC eligibility requirements are met. Employees who are eligible for an individual coverage HRA must be permitted to opt out of and waive future reimbursements on behalf of themselves and all dependents eligible for the individual coverage HRA once each plan year, generally in advance of the first day of the individual coverage HRA's plan year. Participants who become eligible to participate in the individual coverage HRA on a date other than the first day of the plan year or who become eligible fewer

⁵⁸ 85 FR at 29210 – 29211: <https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021#h-57>.

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than 90 days prior to the plan year, and dependents who newly become eligible during the plan year, must also have an opportunity to opt out of the individual coverage HRA during the applicable HRA enrollment period established by the HRA for these individuals.

Employees and their dependents who are provided a QSEHRA are not eligible for APTC or PTC for months in which their QSEHRA is affordable. For plan years beginning in 2020, a QSEHRA is considered affordable for an employee (and dependents, if applicable) if the monthly premium of the self-only second lowest-cost silver plan (SLCSP) available to the employee through the Exchange for the rating area in which the employee resides, minus the monthly self-only amount made available to the employee under the QSEHRA, does not exceed 9.78% of 1/12 of the employee's household income.

If the QSEHRA is not affordable, the employee (and dependents, if applicable) are eligible for the APTC or PTC otherwise allowable for the month reduced by 1/12 of the employee's permitted benefit under the QSEHRA for the year. Therefore, if the employee (and dependents, if applicable) is determined eligible for APTC, they should consider either foregoing APTC or choosing an amount not more than the APTC for which they are eligible minus the QSEHRA amount provided to them. Consumers with a QSEHRA who use more APTC than they're eligible for will likely have to pay some or all of the APTC back when they file their federal income tax return.

18. APPENDIX A – SAMPLE WELCOME LETTER



[Date]

[Insert name]
[Insert address]

Dear [Insert name],

Welcome to Birchwood Health Plan! This letter and package contain important information about your new health insurance coverage.

What's in this package?

- (1) **Summary of Benefits and Coverage/Member Handbook** – A summary of your plan's coverage. It also includes information about your monthly premium and any out-of-pocket costs, like copayments, coinsurance, and deductibles.
- (2) **Prescription Drug Benefits Formulary** – Provides information about medications we cover. You must use network pharmacies to obtain benefits, except under non-routine situations when you cannot reasonably use a network pharmacy.
- (3) **Provider Directory** – Provides information on which providers are in our network. If you use a provider that is not in our network, your costs may be higher than if you use an in-network provider.
- (4) **Information about other coverage (If applicable)** – Provides information about additional coverage such as dental or vision coverage, and health club membership discounts.
- (5) **Member ID Card** – You will be asked to present this each time you get care.
(Included if card is not mailed separately.)

When does my coverage start?

The table below shows who is covered under the Birchwood Health Plan and the start date of coverage. Other members of your household not listed in this table are not covered under this policy.

Enrollee	Plan Name	First Day of Coverage
[Insert name]	Birchwood Health Plan	[Date]
[Insert name]	Birchwood Health Plan	[Date]

Benefits may change from year to year. You will be notified of these changes before the open enrollment period. You can change plans during the open enrollment period or if you qualify for a special enrollment period.

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If Birchwood Health Plan stops offering coverage through the Marketplace for any reason in future years, you will receive a letter before the annual open enrollment period informing you that the plan is no longer available for renewal.

Where can I find additional resources?

You can contact us by phone at the numbers listed below, or you can visit our website at www.birchwoodhealthplan.com. Our website has many tools and resources available to you, including:

- Online account to view an explanation of benefits (EOBs) or make your premium payment
- Electronic copy of prescription drug benefits formulary
- Electronic provider directory
- Quick reference guide
- Notice of privacy policy

You may request paper copies of these documents by calling the Birchwood Health Plan help desk number listed below.

How can I contact Birchwood Health Plan?

If you have any questions or think this letter contains inaccurate information, you can call the Birchwood Health Plan help desk at 1-xxx-xxx-xxxx, Monday through Friday from 8am – 8pm ET, and Saturday and Sunday from 9am-5pm ET.

If you need advice about where and when to get care, you can call our nurse advice line 24 hours a day at 1-xxx-xxx-xxxx.

If you need help finding mental health or substance use disorder care, please call 1-xxx-xxx-xxxx Monday through Friday from 8am – 8pm ET, and Saturday and Sunday from 9am-5pm ET.

If you need information in another language, please call our language line at 1-xxx-xxx-xxxx.

Sincerely,

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

[Insert privacy disclosure and nondiscrimination notice language]

19. APPENDIX B – SAMPLE NON-PAYMENT NOTICE FOR THE INDIVIDUAL MARKET WHERE THE ISSUER HAS ADOPTED THE PAYMENT POLICY ATTRIBUTING PREMIUM PAYMENTS TO PAST DUE PREMIUMS BEFORE BINDER PAYMENTS FOR NEW ENROLLMENT



[Date]

[Insert name]
[Insert address]

Dear [Insert name]:

Important information about your health coverage

This letter includes important information about your family's health insurance from Birchwood Health Plan. You may lose your health insurance coverage because you did not pay your monthly health insurance premium for [month] in the amount of [\$amount] by [the due date].

Since you are getting advance payments of the premium tax credit to help pay for your insurance, you have a three-month grace period to pay your outstanding premium and any new premiums that accrue during this period before your insurance coverage will end. Please be aware that your provider may pend claims for any services you receive during the second and third months of the grace period because your provider may seek to bill you for the services directly if your coverage is terminated for failure to pay your premiums. Your grace period starts on [date] and will end on [date].

What happens if I do not pay my premium?

If you do not pay your [month] premium by the end of the grace period (as well as any additional premiums that become due between now and when you pay), your coverage under Birchwood Health Plan will be terminated back to [date]. If you wait until the final day to make to make any payment, the total amount will be due on that day.

What happens if my coverage ends?

If your coverage ends, you may be responsible for the cost of health services received after your last day of coverage, [date], and, if you are not eligible for a special enrollment period, you may not be able to enroll in another health insurance plan through the Marketplace until the next annual open enrollment period.

Should you later decide to re-enroll in coverage with Birchwood Health Plan or another plan from

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the Birchwood Health Plan group, you will be required to pay all past due premiums for the last 12 months, as well as the required first payment (binder payment) for the new coverage, before the new enrollment will take effect. Past due premiums will include amounts owed for enrollment in any plans in the Birchwood Health Plan group.

When will I be able to enroll in another health insurance plan if my coverage ends?

You can select a qualified health plan for enrollment through the Marketplace during the next annual open enrollment period.

If your circumstances change during the year, like your family size (for example, if you marry, divorce, or have a child), your income, if you move, among other things, you may be eligible for a special enrollment period to enroll in coverage before the annual open enrollment period. You will need to tell the Marketplace if you experience any changes, and they will tell you if you are eligible for a special enrollment period because of the changes. To do this, log into your Marketplace account on HealthCare.gov/marketplace or call 1-800-318-2596 (TTY: 1-855-889-4325). Other events can qualify you for a special enrollment period, too. For more information, visit www.HealthCare.gov.

How do I make a payment?

To make a payment, visit Birchwood Health Plan's website at www.birchwoodhealthplan.com, call member services and select option 2 to make a payment, or send a check with your account number written on it to:

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

If you already mailed your payment for the amount you owe, please disregard this notice.

What if I think this is a mistake?

If you think this information in this letter is a mistake, you need to tell Birchwood Insurance as soon as possible by calling the Birchwood Health Plan help desk at 1-xxx-xxx-xxxx, Monday through Friday from 8am – 8pm ET, and Saturday and Sunday from 9am-5pm ET.

Sincerely,

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

[Insert privacy disclosure and nondiscrimination notice language]

20. APPENDIX C – SAMPLE NON-PAYMENT NOTICE FOR THE INDIVIDUAL MARKET WHERE THE ISSUER HAS NOT ADOPTED THE PAYMENT POLICY ATTRIBUTING PREMIUM PAYMENTS TO PAST DUE PREMIUMS BEFORE BINDER PAYMENTS FOR NEW ENROLLMENT



[Date]

[Insert name]
[Insert address]

Dear [Insert name]:

Important information about your health coverage

This letter includes important information about your family's health insurance from Birchwood Health Plan. You may lose your health insurance coverage because you did not pay your monthly health insurance premium for [month] in the amount of [\$amount] by [the due date].

Since you are getting advance payments of the premium tax credit to help pay for your insurance, you have a three-month grace period to pay your outstanding premium and any new premiums that accrue during this period before your insurance coverage will end. Please be aware that your provider may pend claims for any services you receive during the second and third months of the grace period because your provider may seek to bill you for the services directly if your coverage is terminated for failure to pay your premiums. Your grace period starts on [date] and will end on [date].

What happens if I do not pay my premium?

If you do not pay your [month] premium by the end of the grace period (as well as any additional premiums that become due between now and when you pay), your enrollment in Birchwood Health Plan will be terminated back to [date]. If you wait until the final day to make to make any payment, the total amount will be due on that day.

What happens if my coverage ends?

If your coverage ends, you may be responsible for the cost of health services received after your last day of coverage, [date], and, if you are not eligible for a special enrollment period, you may not be able to enroll in another health insurance plan through the Marketplace until the next annual open enrollment period.

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When will I be able to enroll in another health insurance plan if my coverage ends?

You can select a qualified health plan for enrollment through the Marketplace during the next annual open enrollment period.

If your circumstances change during the year, like your family size or circumstances (for example, if you marry, divorce, or have a child), your income, or if you move, among other things, you may be eligible for a special enrollment period to enroll in coverage before the annual open enrollment period. You will need to tell the Marketplace if you experience any changes, and they will tell you if you are eligible for a special enrollment period because of the changes. To do this, log into your Marketplace account on [HealthCare.gov/marketplace](https://www.healthcare.gov/marketplace) or call 1-800-318-2596 (TTY: 1-855-889-4325). Other events can qualify you for a special enrollment period, too. For more information, visit [www.HealthCare.gov](https://www.healthcare.gov).

How do I make a payment?

To make a payment, visit Birchwood Health Plan's website at www.birchwoodhealthplan.com, call member services and select option 2 to make a payment, or send a check with your account number written on it to:

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

If you already mailed your payment for the amount you owe, please disregard this notice.

What if I think this is a mistake?

If you think this information in this letter is a mistake, you need to tell Birchwood Insurance as soon as possible by calling the Birchwood Health Plan help desk at 1-xxx-xxx-xxxx, Monday through Friday from 8am – 8pm ET, and Saturday and Sunday from 9am-5pm ET.

Sincerely,

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

[Insert privacy disclosure and nondiscrimination notice language]

21. APPENDIX D – SAMPLE TERMINATION LETTER



[Date]

[Insert name]
[Insert address]

Dear [Insert name],

Important: Your health insurance coverage is ending

This letter includes important information about your family's health insurance from Birchwood Health Plan. [insert name] and [insert name] will no longer have health insurance coverage from Birchwood Health Plan on [insert termination effective date], because you requested that Birchwood terminate your insurance. You requested to terminate your insurance by [insert description—e.g., calling our help desk on July 20, 20XX].

The table below shows whose health insurance coverage will be terminated, the last day of coverage, and why the insurance is ending. Any other members of your household not listed in this letter will not be affected.

Enrollee	Plan Name	Last Day of Coverage	Reason for disenrollment
[insert name]	Birchwood Health Plan	[insert termination effective date]	[insert reason—e.g., Requested to terminate coverage]
[insert name]	Birchwood Health Plan	[insert termination effective date]	[insert reason—e.g., Requested to terminate coverage]

What happens when my coverage ends?

If you terminate your coverage and do not get other health coverage, you may be fully responsible for the cost of health services that you receive after your coverage ends. If you are not eligible for a special enrollment period, you may not be able to enroll in another health insurance plan through the Marketplace until the next annual open enrollment period.

When will I be able to enroll in another health insurance plan?

You can select a qualified health plan through the Health Insurance Marketplace® website at www.HealthCare.gov during the next annual open enrollment period.

If your circumstances change during the year, like your family size (for example, if you marry, divorce, or have a child), your income, or if you move, among other things, you may be eligible

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for a special enrollment period to enroll in coverage before the annual enrollment period. You need to tell the Marketplace if you experience any changes, and they will tell you if you are eligible for a special enrollment period because of the changes. To do this, log into your Marketplace account on [HealthCare.gov/marketplace](https://www.HealthCare.gov/marketplace) or call 1-800-318-2596 (TTY: 1-855-889-4325). For more information, visit www.HealthCare.gov.

What if I think there's a mistake?

If you think the information included in this letter is a mistake and you did not request termination of coverage, you need to tell Birchwood Insurance right away by calling the Birchwood Health Plan help desk at 1-xxx-xxx-xxxx, Monday through Friday from 8am – 8pm ET, and Saturday and Sunday from 9am-5pm ET.

Sincerely,

Birchwood Health Plan
23 West Drive, Suite 300
Jacksonville, FL 32202

[Insert privacy disclosure and nondiscrimination notice language]

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This Notice has Important Information. This notice has important information about your application or coverage through the Health Insurance Marketplace. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-800-318-2596 and wait through the opening. When an agent answers, state the language you need and you'll be connected with an interpreter.

العربية (Arabic) يحتوي هذا الإشعار على معلومات هامة بخصوص طلبك أو تغطيتك من خلال سوق التأمين الصحي. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد تحتاج إلى اتخاذ إجراء في مواعيد معينة للحفاظ على تغطيتك الصحية أو المساعدة في التكاليف. لك الحق في الحصول على هذه المعلومات وعلى المساعدة بلغتك من دون أي تكلفة. اتصل برقم 1-800-318-2596 و انتظر عند سماعك الافتتاحية. عندما يجيبك الممثل فم بتحديد اللغة التي تحتاج و سيجري وملك بالمترجم.

中文 (Chinese) 本通知包含您通过健康保险市场的申请或保险范围方面的重要信息。查阅本通知中的重要日期。您可能需要在某些截止日期前采取行动以续保或有助于节省某些费用。您有权免费获取本信息以及您所使用语种的帮助。请致电 1-800-318-2596 并聽完全部錄音。當有代表接聽時，請說明您所需的语种，届时将有译员与您联系。

Français (French) Cet avis contient des informations importantes concernant votre demande ou votre couverture à travers le Marché d'assurance maladie. Recherchez les dates clés dans le présent avis. Vous pourrez avoir besoin de prendre des mesures avant certaines dates limites afin de garder votre couverture santé ou de vous aider avec les coûts. Vous avez le droit d'obtenir ces informations et de l'aide dans votre langue sans frais. Appelez le 1-800-318-2596 et appuyez sur « 0 » à deux reprises attendre à travers l'ouverture. Quand l'agent répond indiquez la langue dont vous avez besoin et vous serez mis en relation avec un interprète.

Kreyòl (French Creole) Avi sa a gen enfòmasyon enpòtan sou aplikasyon w lan oswa pwoteksyon atravè Health Insurance Marketplace la. Gade pou dat kle nan avi sa a. Ou ka bezwen pran aksyon payon sèten dat limit pou ou kenbe asirans sante ou oswa ed ak depans yo. Ou gen dwa pou ou jwenn enfòmasyon sa a akèd nan lang ou sanpa sa pa koute ou anyen. Rele 1-800-318-2596 epi rete tann ouvèti an. Lè yon ajan reponn, di lang ou bezwen an epi ou pral konekte ak yon entèprèt.

Deutsch (German) Diese Benachrichtigung enthält wichtige Informationen zu Ihrem Antrag oder Versicherung durch den Health Insurance Marketplace. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie müssen möglicherweise bis zu bestimmten Stichtagen handeln, um Ihre Krankenversicherung aufrechtzuerhalten oder Hilfe mit Kosten zu erhalten. Sie haben das Recht, diese Informationen und Hilfe in Ihrer Sprache kostenlos zu erhalten. Rufen Sie 1-800-318-2596 an und warten Sie die Ansage ab. Wenn sich ein Mitarbeiter meldet, wählen Sie die Sprache aus, die Sie benötigen und Sie werden mit einem Dolmetscher verbunden.

ગુજરાતી (Gujarati) આ સૂચનામાં આરોગ્યવીમા માફેટરશન સમારકુતેતમારીઅરજીઅથવા સર્વગ્રાહી વીમો વિશેનીમહત્વનીમાહિતીછે. આ સૂચનામાંમહત્વનીતારીખોમાટેજુઓ. તમેતમારાઆરોગ્યઆવરીલેવાઅથવાખર્ચમાંમદદકરવામાટેઅમુકચોક્કસ નિશ્ચિત સમય ને રદમાં લેવાનામાંરાખીનેપગલાંલેવાનીજરૂરપડેછે. મનેકોઈપણખર્ચવિનાતમારીભાષામાંઆજાણકરીઅનેમદદમેળવવાનોઅધિકારછે. 1-800-318-2596 અને શરૂઆતના મારકુતે રાફ જુઓ. એક એજન્ટ જવાબ આપે, ત્યારે તેમને તમે જરૂરી ભાષા જણાવો અને તમને દુભાષિયો સાથે જોડવામાં આવશે.

Italiano (Italian) Questo avviso contiene importanti informazioni. Questo avviso contiene importanti informazioni riguardo la sua richiesta o copertura assicurativa tramite l'Health Insurance Marketplace. Controlli le date più importanti di questo avviso. Potrebbe avere la necessità di compiere alcune azioni al fine di conservare la sua copertura medica o per ridurne i costi. Ha il diritto di ricevere queste informazioni ed assistenza nella sua lingua senza costi aggiuntivi. Chiami al 1-800-318-2596 e resti in attesa del primo operatore disponibile. Quando un nostro operatore risponderà, comunichi la lingua di cui ha bisogno e sarà collegato/a con un interprete.

日本語 (Japanese) この通知には重要な情報が含まれています。この通知には、Health Insurance Marketplace 経由のアプリケーションまたは補償範囲に関する重要な情報が含まれます。この通知では、重要な期日について確認してください。補償範囲や費用サポートを維持するには、指定の期日までにご対応いただく必要がある場合があります。これらの情報を無料で取得する権利および希望の言語でサポートを受ける権利があります。1-800-318-2596にお問い合わせいただき、つながるまでお待ちください。エージェントにつながりましたら、必要とする言語をお伝え下さい。通訳者とつながります。



FFEs and FF-SHOP Enrollment

한국어 (Korean) 이 통지서에는 건강 보험 시장을 통한 귀하의 신청이나 보험 커버리지에 관한 중요한 정보가 포함되어 있습니다. 이 통지서에 나타난 중요한 날짜들을 잘 찾아 보십시오. 귀하는 귀하의 보험 커버리지를 계속 유지시키거나 경비를 절감하는 도움을 얻기 위해서 일정한 마감일 까지 필요한 조치를 취해야 할 수도 있습니다. 귀하는 귀하의 언어로 이 정보와 도움을 무료로 받을 수 있는 권리가 있습니다. 1-800-318-2596 로 전화하시고 시작하기 전에 기다리십시오. 직원이 전화를 받으면 귀하가 필요한 언어를 말씀하십시오. 그러면 통역사와 연결될 것입니다.

Polski (Polish) To ogłoszenie zawiera ważne informacje dotyczące Państwa wniosku o ubezpieczenie lub polisy zdrowotnej zakupionej przez Rynek Ubezpieczeń Zdrowotnych. Prosimy zwrócić uwagę na kluczowe daty zawarte w tym ogłoszeniu aby przy podejmowaniu ewentualnych decyzji dotyczących odnowienia polisy lub pomocy związanej z kosztami, nie przekroczyć terminów. Macie Państwo prawo do bezpłatnej informacji we własnym języku. W tym celu prosimy o telefon pod numer 1 800 318 2596, następnie proszę poczekać na zgłoszenie się operatora i wypowiedzenie preferowane go języka a rozmowa zostanie przełączona do tłumacza.

Português (Portuguese) Este aviso contém informações importantes sobre sua aplicação ou cobertura ao longo do Mercado de Planos de Saúde (Health Insurance Marketplace). Observe as datas importantes nesse aviso. Você poderá precisar tomar medidas, até determinados prazos, para manter sua cobertura médica ou ajuda de custo. Você tem o direito de obter tais informações e auxílio em seu idioma, sem custo algum. Ligue para 1-800-318-2596 e espere através da introdução. Quando o agente atende, afirme o idioma que precisa e você será transferido para um intérprete.

Русский (Russian) В настоящем уведомлении содержится важная информация о вашей страховке через рынок медицинского страхования. Вы можете найти важные даты в данном уведомлении. Возможно, вам придется предпринять некоторые действия к конкретным срокам, с тем, чтобы сохранить вашу медицинскую страховку или финансовую помощь на медицинские расходы. Вы имеете право на получение этой информации и помощи на родном языке бесплатно. Позвоните по номеру 1-800-318-2596 и прослушайте вступительную информацию до конца. Когда ответит агент, укажите необходимый язык, и вас соединят с переводчиком.

Español (Spanish) Este aviso contiene información importante sobre su solicitud o la cobertura que tiene a través del Mercado de Seguros Médicos. Consulte las fechas importantes que figuran aquí. Es probable que deba tomar medidas antes de algunas fechas clave para mantener su cobertura de salud o seguir recibiendo ayuda para pagar los costos. Usted tiene derecho a recibir esta información y asistencia en su idioma en forma gratuita. Llame al 1-800-318-2596 y espere a través de la introducción. Cuando el agente atiende, indique el idioma que necesita y lo pondrán en comunicación con un intérprete.

Tagalog (Tagalog) Ang paunawa na ito ay may nilalamang mahalagang impormasyon tungkol sa iyong aplikasyon o kaseguruhan sa pamamagitan ng Health Insurance Marketplace. Tingnan ang mga mahalagang petsa sa paunawang ito. Maaring mangailangang gumawa ka ng hakbang sa loob ng mga itinakdang petsa upang mapanatili ang iyong kaseguruhang pangkalusugan o makatanggap ng tulong sa mga gastos. Mayroon kang karapatang makuha ang impormasyon na ito at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-318-2596 at maghintay ng pagkakataong mabuksan ang linya. Kapag sumagot ang isang ahente, sabihin ang kailangan mong wika at ikaw ay iuugnay sa isang tagapagsalin sa Tagalog.

Tiếng Việt (Vietnamese) Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm của chương trình Thị trường bảo hiểm sức khỏe Marketplace. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi 1-800-318-2596 và đợi nghe hết lời mở đầu do máy nói. Cho tới khi gặp một nhân viên trả lời, xin nói ngôn ngữ của mình là gì và quý vị sẽ được kết nối với một thông dịch viên.

